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MEDICARE AMENDMENTS OF 1980

REPORT

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

U.S. HOUSE OF REPRESENTATIVES

TO ACCOMPANY

H.R. 3990

together with

ADDITIONAL VIEWS

[Including cost estimate of the Congressional Budget Office]

MARCH 18, 1980.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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MEDICARE AMENDMENTS OF 1980

MARCH 18, 1980.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. STAGGERS, from the Committee on Interstate and Foreign Commerce, submitted the following

REPORT

together with

ADDITIONAL VIEWS

[To accompany H.R. 3990 which on May 8, 1979, was referred jointly to the Committee on Ways and Means and the Committee on Interstate and Foreign Commerce.]

[Including cost estimate of the Congressional Budget Office]

The Committee on Interstate and Foreign Commerce, to whom was referred the bill (H.R. 3990) to amend certain provisions of title XVIII of the Social Security Act with respect to the medicare program established by such title, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is a follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

SHORT TITLE; TABLE OF CONTENTS

SECTION 1. This Act may be cited as the "Medicare Amendments of 1980."

TABLE OF CONTENTS

Sec. 1. Short title; table of contents.
Sec. 2. Home health services.
Sec. 3. Elimination of second waiting period for reentitled disability beneficiaries.
Sec. 4. Report on coverage of medicare beneficiaries outside the United States.
Sec. 5. Dentists' services.
Sec. 6. Treatment of plantar warts.
Sec. 7. Community mental health centers.
Sec. 8. Comprehensive outpatient rehabilitation facility services.
Sec. 9. Optometrists' services.
Sec. 10. Antigens.
Sec. 11. Payment where beneficiary not at fault.
Sec. 12. Flexibility in application of standards to rural hospitals.
Sec. 13. Certification and utilization review by podiatrists.
Sec. 14. Physician treatment plan for speech pathology.
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Sec. 16. Presumed coverage provisions.
Sec. 17. Payment to providers of services.
Sec. 18. Limit on premium increases due to late enrollment.
Sec. 19. Reenrollment and open enrollment in part B.
Sec. 20. Chiropractors' services.
Sec. 21. Increase in outpatient mental health benefits under part B.
Sec. 22. Limitation on payments to radiologists and pathologists.
Sec. 23. Shortened part B termination period for certain individuals whose premiums medicaid has ceased to pay.
Sec. 24. Outpatient physical therapy services.
Sec. 25. Medicare coverage of pneumococcal vaccine and its administration.
Sec. 26. Medicare payment liability secondary in certain automobile insurance cases.
Sec. 27. Hospital transfer requirement for skilled nursing facility coverage.
Sec. 28. Outpatient surgery.
Sec. 29. Technical renal disease amendments.
Sec. 30. Preadmission diagnostic testing.
Sec. 31. Studies and demonstration projects.
Sec. 32. Provider reimbursement review board.
Sec. 33. Access to books and records of subcontractors.

HOME HEALTH SERVICES

SEC. 2. (a) Section 1811 of the Social Security Act is amended by striking out "and related post-hospital services" and inserting in lieu theref ", related post-hospital, and home health services".

(b) Section 1812(a)(3) of such Act is amended to read as follows:

"(3) home health services.".

(c) Section 1812(d) of such Act is repealed.

(d) Section 1812(e) of such Act is amended—

(1) by striking out "(b), (c), and (d)" and inserting in lieu thereof "(b) and (c)"; and

(2) by striking out "post-hospital extended care services, and post-hospital home health services" and inserting in lieu thereof "and post-hospital extended care services".

(e) Sections 1814(a) and 1835(a) of such Act are amended by adding the following new sentence at the end of each such section: "With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than June 30, 1980, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan.".

(f) Section 1814(a)(2)(D) of such Act is amended—

(1) by striking out "post-hospital home health services" and inserting in lieu thereof "home health services";

(2) by inserting ", occupational," after "or physical"; and

(3) by striking out ", for any of the conditions" and all that follows through "extended care services".

(g) Section 1832(a)(2)(A) of such Act is amended by striking out "for up to 100 visits during a calendar year".

(h) Section 1833(b) of such Act is amended—

(1) by striking out "and" at the end of clause (1) in the first sentence; and

(2) by striking out the period at the end of the first sentence and inserting in lieu thereof the following: ", and (3) such deductible shall not apply with respect to home health services.".

(i) Section 1834 of such Act is repealed.

(j) Section 1835 (a)(2)(A) of such Act is amended by inserting ", occupational," after "or physical".

(k) Section 1861(e) of such Act is amended—

(1) by striking out "subsections (i) and (n)" in the material preceding paragraph (1) and inserting in lieu thereof "subsection (i)"; and

(2) by striking out "subsections (i) and (n)" in the third sentence and inserting in lieu thereof "subsection (i)".

(l) Section 1861(m)(4) of such Act is amended by inserting the following before the semicolon: "who has successfully completed a training program approved by the Secretary".

(m) Section 1861(n) of such Act is repealed.

(n) Section 1861(o) of such Act is amended—

(1) by striking out "and" at the end of paragraph (5), by inserting "and" at the end of paragraph (6), and by adding the following new paragraph after paragraph (6):

"(7) meets such additional requirements (including conditions relating to bonding or establishing of escrow accounts as the Secretary finds necessary for the financial security of the program) as the Secretary finds necessary for the effective and efficient operation of the program;"; and

(2) by striking out "except that" the first time it appears in the material following paragraph (6) and all that follows through "regulations; and".

(o) Section 1816(e) of such Act is amended—

(1) by inserting "(subject to the provisions of paragraph (4))" after "the Secretary may" in paragraph (2); and

(2) by adding the following new paragraph at the end thereof:

"(4) Notwithstanding subsections (a) and (d) and paragraphs (1), (2), and (3) of this subsection, the Secretary shall designate regional agencies or organizations which have entered into an agreement with him under this section to perform functions under such agreement with respect to home health agencies (as defined in section 1861(o)) in the region, except that in assigning such agencies to such designated regional agencies or organizations the Secretary shall assign a home health agency which is a subdivision of a hospital (and such agency and hospital are affiliated or under common control) only if, after applying such criteria relating to administrative efficiency and effectiveness as he shall promulgate, he determines that such assignment would result in the more effective and efficient administration of this title.".

(p) Section 1861(v)(1) of such Act is amended by adding the following new subparagraph at the end thereof:

"(G) In determining such reasonable cost with respect to home health agencies, the Secretary may not include—

"(i) any costs incurred in connection with bonding or establishing an escrow account by any such agency as a result of the financial security requirement described in subsection (o)(7);

"(ii) in the case of home health agencies to which the financial security requirement described in subsection (o)(7) applies, any costs attributed to interest charged such an agency in connection with amounts borrowed by the agency to repay overpayments made under this title to the agency, except that such costs may be included in reasonable cost if the Secretary determines that the agency was acting in good faith in borrowing the amounts;

"(iii) in the case of contracts entered into by a home health agency after the date of enactment of this subparagraph for the purpose of having services furnished for or on behalf of such agency, any cost incurred by such agency pursuant to any such contract (I) which is entered into for a period exceeding five years, or (II) which determines the amount payable by the home health agency on the basis of a percentage of the agency's reimbursement or claim for reimbursement for services furnished by the agency; and

"(iv) in the case of contracts entered into by a home health agency before the date of enactment of this subparagraph for the purpose of having services furnished for or on behalf of such agency, any cost incurred by such agency pursuant to any such contract, which determines the amount payable by the home health agency on the basis of a percentage of the agency's reimbursement or claim for reimbursement for services furnished by the

agency, to the extent that such cost exceeds the reasonable value of the services furnished on behalf of such agency.".

(q) Section 226(c)(1) of such Act is amended—

(1) by striking out "and post-hospital home health services" and inserting in lieu thereof "and home health services"; and

(2) by striking out " or post-hospital home health services" in clause (B).

(r) Section 7(d)(1) of the Railroad Retirement Act of 1974 is amended by striking out "posthospital home health services" and inserting in lieu thereof "home health services".

(s)(1) The amendments made by this section shall become effective with respect to services furnished on or after July 1, 1980, except that the amendments made by subsections (n) and (o) shall become effective on the date of the enactment of this Act.

(2) The Secretary shall take administrative action to assure that improvements, in accordance with the amendment made by subsection (n)(1), will be made with respect to home health services by June 30, 1980.

ELIMINATION OF SECOND WAITING PERIOD FOR REENTITLED DISABILITY BENEFICIARIES

SEC. 3. (a)(1)(A) Section 226(b)(2) of the Social Security Act is amended by striking out "consecutive" in clauses (A) and (B).

(B) Section 226(b) of such Act is further amended by striking out "consecutive" in the matter following paragraph (2).

(2) Section 1811 of such Act is amended by striking out "consecutive".

(3) Section 1837(g)(1) of such Act is amended by striking out "consecutive".

(4) Section 7(d)(2)(ii) of the Railroad Retirement Act of 1974 is amended by striking out "consecutive" each place it appears.

(b) Section 226 of the Social Security Act is amended by redesignating subsection (f) as subsection (g), and by inserting after subsection (e) the following new subsection:

"(f) For purposes of subsection (b) (and for purposes of section 1837(g)(1) of this Act and section 7(d)(2)(ii) of the Railroad Retirement Act of 1974), the 24 months for which an individual has to have been entitled to specified monthly benefits on the basis of disability in order to become entitled to hospital insurance benefits on such basis effective with any particular month (or to be deemed to have enrolled in the supplementary medical insurance program, on the basis of such entitlement, by reason of section 1837(f)), where such individual had been entitled to specified monthly benefits of the same type during a previous period which terminated—

"(1) more than 60 months before that particular month in any case where such monthly benefits were of the type specified in clause (A)(i) or (B) of subsection (b)(2), or

"(2) more than 84 months before that particular month in any case where such monthly benefits were of the type specified in clause (A)(ii) or (A)(iii) of such subsection,

shall not include any month which occurred during such previous period.".

(c) The amendments made by this section shall apply with respect to hospital insurance or supplementary medical insurance benefits for months after the month in which this Act is enacted.

REPORT ON COVERAGE OF MEDICARE BENEFICIARIES OUTSIDE THE UNITED STATES

SEC. 4. (a) The Secretary of Health, Education, and Welfare shall provide for a study of—

(1) the number of individuals, entitled to benefits under title XVIII of the Social Security Act, who, because medical services were furnished to them while they were residing or traveling outside the United States, have been unable under such title to have payments made with respect to such services, and the approximate amount of such payments not provided, and

(2) the desirability and feasibility of the different alternatives, including reciprocal agreements between the United States and foreign nations, to provide for such benefits or comparable benefits for services furnished outside the United States.

(b) The Secretary shall report to the Congress, not later than one year after the date of the enactment of this Act, on such study and shall include in such report such recommendations for legislative changes as may be appropriate.

DENTISTS' SERVICES

SEC. 5. (a) Clause (2) of the first sentence of section 1861(r) of the Social Security Act is amended to read as follows: "(2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions,".

(b) Section 1814(a)(2)(E) of such Act is amended to read as follows:

"(E) in the case of inpatient hospital services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services;

(c) Section 1862(a)(12) of such Act is amended by inserting "or because of the severity of the dental procedure" after "clinical status".

TREATMENT OF PLANTAR WARTS

SEC. 6. Section 1862(a)(13)(C) of the Social Security Act is amended by striking out ", warts,".

COMMUNITY MENTAL HEALTH CENTERS

SEC. 7. (a) Section 1832(a)(2) of the Social Security Act is amended by striking out "and" at the end of subparagraph (C), by striking out the period at the end of subparagraph (D) and inserting in lieu thereof a semicolon, and by adding the following new subparagraph at the end thereof:

"(E) community mental health center services;".

(b) Section 1832(a)(2)(B)(i) of such Act is amended by striking out "or" at the end of subclause (I), by striking out "and" at the end of subclause (II) and inserting in lieu thereof "or", and by adding the following new subclause after subclause (II):

"(III) a physician to a patient in a community mental health center or to a patient in a comprehensive outpatient rehabilitation facility; and".

(c) Section 1833(c) of such Act is amended by inserting "and not a patient of a community mental health center" after "of a hospital".

(d) Title XVIII of such Act is amended by adding the following new section after section 1833:

"LIMITATION ON COMMUNITY MENTAL HEALTH CENTER SERVICES

"SEC. 1834. Payment under this part may be made for community mental health center services furnished an individual for—

"(1) up to 15 outpatient visits during any calendar year; and

"(2) up to 60 partial hospitalization visits to such a center during any calendar year.

Services shall be taken into account for purposes of paragraphs (1) and (2) only if payment is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1835(a), made with respect to such services under this part.".

(e) Section 1835(a)(2) of such Act is amended by striking out the period at the end of subparagraph (D) and inserting in lieu thereof a semicolon, and by inserting the following new subparagraph after subparagraph (D):

"(E) in the case of community mental health center services, (i) such services are or were required in connection with the treatment of mental, psychoneurotic, or personality disorders, (ii) a plan for furnishing such services has been established by a physician (as defined in section 1861(r)(1)) or qualified mental health professional (as defined in section 1861(bb)(3)) and is periodically reviewed and approved by a physician,

(iii) such services are or were furnished while the individual is or was under the case management of a physician (as defined in section 1861(r)(1)), and (iv) in the case of services provided with respect to a partial hospitalization visit, the individual would otherwise require or have required (in the professional judgment of such physician) inpatient psychiatric services;".

(f) Section 1861(l) of such Act is amended by inserting "or community mental health center" after "nursing facility" each time it appears therein.

(g) Section 1861(u) of such Act is amended by inserting "community mental health center," after "home health agency,".

(h) Section 1861(w)(1) of such Act is amended by inserting "community mental health center.", after "nursing facility,".

(i) Section 1861 of such Act is amended by adding the following new subsection at the end thereof:

"Community Mental Health Center Services

"(bb)(1) The term 'community mental health center services' means the following items and services furnished to an individual as an outpatient by a community mental health center or (to the extent permitted in regulations by the Secretary) by others under arrangements with them made by the center—

"(A) diagnostic, therapeutic, or rehabilitative services furnished at the facility and crisis intervention outside the facility, when furnished by a physician (as defined in subsection (r)(1)) or a qualified mental health professional (as defined in paragraph (3));

"(B) drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered; and

"(C) such items and supplies as are ordinarily furnished to outpatients by community mental health centers in connection with an active mental health program of diagnosis and treatment.

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital.

"(2) The term 'community mental health center' means a facility which—

"(A) meets the definition of a community mental health center under section 201 of the Community Mental Health Centers Act and the regulations prescribed thereunder;

"(B) has a requirement that all mental health services are provided under the supervision of a physician or other qualified mental health professional;

"(C) meets such requirements as the Secretary may prescribe with respect to staffing requirements and qualifications of the staff;

"(D) maintains clinical records on all patients;

"(E) has in effect a utilization review plan in accordance with regulations prescribed by the Secretary;

"(F) has in effect an agreement with a hospital pursuant to subsection (1);

"(G) in the case of a community mental health center in any State in which State or applicable local law provides for the licensing of community mental health centers, is licensed pursuant to such law;

"(H) has appropriate procedures or arrangements (in compliance with applicable State and Federal law) for storing, administering, and dispensing drugs and biologicals; and

"(I) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such center.

"(3) The term 'qualified mental health professional' means a clinical psychologist, psychiatric nurse, or psychiatric social worker who has such qualifications as the Secretary shall establish by regulation.".

(j) Section 164(a) of such Act is amended—

(1) by inserting ", or whether a facility therein is a community mental health center as defined in section 161(bb)(2)" before the period at the end of the first sentence;

(2) by inserting "or a community mental health center" after "home health agency" in the second sentence; and

(3) by inserting "community mental health center," after "laboratory," each time it appears in the fifth sentence.

(k) The amendments made by this section shall become effective with respect to a community mental health center's first accounting period which begins on or after March 1, 1980.

(l) The Secretary of Health, Education, and Welfare shall submit a report, not later than twenty-four months after the date of the enactment of this Act, to the Congress recommending a definition of an outpatient mental health center which could be used to broaden the definition of community mental health center as established by the amendments made by this section, especially the part of that definition which requires that such a center meet the definition of section 201 of the Community Mental Health Centers Act.

COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY SERVICES

SEC. 8. (a) Section 1832(a)(2) of the Social Security Act is amended by adding the following new subparagraph at the end thereof after the new subparagraph added by section 7(a) of this Act:

"(F) comprehensive outpatient rehabilitation facility services; and".

(b) Section 1835(a)(2) of such Act is amended by inserting the following new subparagraph at the end thereof after the new subparagraph added by section 7(e) of this Act:

"(F) in the case of comprehensive outpatient rehabilitation facility services, (i) such services are or were required because the individual needed skilled rehabilitation services, (ii) a plan for furnishing such services has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician; and".

(c) Section 1861(u) of such Act is amended by inserting "comprehensive outpatent rehabilitation facility," immediately after "skilled nursing facility,".

(d) Section 1861(z) of such Act is amended by striking out "extended care facility," and inserting in lieu thereof "skilled nursing facility, comprehensive outpatient rehabilitation facility,".

(e) Section 1861 of such Act is amended by adding the following new subsection at the end thereof after the new subsection added by section 7(i) of this Act:

"COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY SERVICES

"(cc)(1) The term 'comprehensive outpatient rehabilitation facility services' means the following items and services furnished by a physician or other qualified professional personnel (as defined in regulations by the Secretary) to an individual who is an outpatient of a comprehensive outpatient rehabilitation facility under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician—

"(A) physicians' services;

"(B) physical therapy, occupational therapy, speech pathology services, and respiratory therapy;

"(C) prosthetic and orthotic devices, including testing, fitting, or training in the use of prosthetic and orthotic devices;

"(D) social and psychological services;

"(E) nursing care provided by or under the supervision of a registered professional nurse;

"(F) drugs and biologicals which cannot, as determined in accordance with regulations, be self administered;

"(G) supplies, appliances, and equipment, including the purchase or rental of equipment; and

"(H) such other items and services as are medically necessary for the rehabilitation of the patient and are ordinarily furnished by comprehensive outpatient rehabiltation facilities,

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an outpatient of a hospital.

"(2) The term 'comprehensive outpatient rehabilitation facility' means a facility which—

"(A) is primarily engaged in providing (by or under the supervision of physicians) diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons;

"(B) provides at least the following comprehensive outpatient rehabilitation services: (i) Physicians' services (rendered by physicians, as defined in section 1861(r)(1), who are available at the facility on a full- or part-time basis); (ii) physical therapy; and (iii) social or psychological services;

"(C) maintains clinical records on all patients;

"(D) has policies established by a group of professional personnel (associated with the facility), including one or more physicians defined in subsection (r)(1) to govern the comprehensive outpatient rehabilitation services it furnishes, and provides for the carrying out of such policies by a full- or part-time physician referred to in subparagraph (B)(i);

"(E) has a requirement that every patient must be under the care of a physician;

"(F) in the case of a facility in any State in which State or applicable local law provides for the licensing of facilities of this nature (i) is licensed pursuant to such law, or (ii) is approved by the agency of such State or locality, responsible for licensing facilities of this nature, as meeting the standard establishment for such licensing;

"(G) has in effect a utilization review plan in accordance with regulations prescribed by the Secretary;

"(H) has in effect an overall plan and budget that meets the requirements of subsection (3); and

"(I) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such facility, including conditions concerning qualifications of personnel in these facilities.".

(f) Section 1863 of such Act is amended by striking out "and (o)(6)" in the first sentence and inserting in lieu thereof "(o)(6), and (cc)(2)(I)".

(g) Section 1864(a) of such Act is amended—

(1) by inserting "or a comprehensive outpatient rehabilitation facility as defined in section 1861(cc)(2)" after "section 1861(aa)(2)" in the first sentence; and

(2) by inserting "comprehensive outpatient rehabilitation facility," after "rural health clinic," each time it appears in the second and fifth sentences.

(h) The amendments made by this section shall become effective with respect to a comprehensive outpatient rehabilitation facility's first accounting period which begins on or after March 1, 1980.

OPTOMETRISTS' SERVICES

SEC. 9. (a) Clause (4) of the first sentence of section 1861(r) of the Social Security Act is amended by striking out "but only with respect to establishing the necessity for prosthetic lenses," and inserting in lieu thereof "but only with respect to services related to the condition of aphakia,".

(b) The Secretary of Health, Education, and Welfare shall submit to the Congress by June 1, 1980, legislative recommendations with respect to reimbursement under title XVIII of the Social Security Act for services furnished by optometrists in connection with cataracts and such other services which they are legally authorized to perform.

ANTIGENS

SEC. 10. Section 1861(s)(2) of the Social Security Act is amended by striking out "and" at the end of subparagraph (E), by inserting "and" at the end of subparagraph (F), and by inserting the following new subparagraph after subparagraph (F):

"(G) antigens (subject to quantity limitations prescribed in regulations by the Secretary) prepared by a physician, as defined in section 1861(r)(1), for a particular patient, including antigens so prepared which are forwarded to another qualified person (including a rural health clinic) for administration to such patient, from time to time, by or under the supervision of another such physician;".

PAYMENT WHERE BENEFICIARY NOT AT FAULT

SEC. 11. Section 1879 of the Social Security Act is amended by adding the following new subsection at the end thereof:

"(e) Where payment for inpatient hospital services or extended care services may not be made under part A of this title on behalf of an individual entitled to benefits under such part solely because of an unintentional, inadvertent, or erroneous action with respect to the transfer of such individual from a hospital or skilled nursing facility that meets the requirements of sections 1861 (e) or (j) by such a provider of services acting in good faith in accordance with the advice of a utilization review committee, professional standards review organization, or fiscal intermediary, or on the basis of a clearly erroneous administrative decision by a provider of services, the Secretary shall take such action with respect to the payment of such benefits as he determines may be necessary to correct the effects of such unintentional, inadvertent, or erroneous action.".

FLEXIBILITY IN APPLICATION OF STANDARDS TO RURAL HOSPITALS

SEC. 12. Section 1861(e) of the Social Security Act is amended by adding the following new sentence at the end thereof: "The term 'hospital' also includes a facility of fifty beds or less which is located in an area determined by the Secretary to meet the definition relating to a rural area described in subparagraph (A) of paragraph (5) of this subsection and which meets the other requirements of this subsection, except that—

"(A) with respect to the requirements for nursing services applicable after December 31, 1978, such requirements shall provide for temporary waiver of the requirements, for such period as the Secretary deems appropriate, where (i) the facility's failure to fully comply with the requirements is attributable to a temporary shortage of qualified nursing personnel in the area in which the facility is located, (ii) a registered professional nurse is present on the premises to render or supervise the nursing service provided during at least the regular daytime shift, and (iii) the Secretary determines that the employment of such nursing personnel as are available to the facility during such temporary period will not adversely affect the health and safety of patients;

"(B) with respect to the health and safety requirements promulgated under paragraph (9), such requirements shall be applied by the Secretary to a facility herein defined in such manner as to assure that personnel requirements take into account the availability of technical personnel and the educational opportunities for technical personnel in the area in which such facility is located, and the scope of services rendered by such facility; and the Secretary, by regulations, shall provide for the continued participation of such a facility where such perosnnel requirements are not fully met, for such period as the Secretary determines that (i) the facility is making good faith efforts to fully comply with the personnel requirements, and (ii) the employment by the facility of such personnel as are available to the facility will not adversely affect the heath and safety of patients; and

"(C) with respect to the fire and safety requirements promulgated under paragraph (9), the Secretary may (i) waive, for such period as he deems appropriate, specific provisions of such requirements which if rigidly applied would result in unreasonable hardship for such a facility and which, if not applied, would not jeopardize the health and safety of patients, and (ii) may accept a facility's compliance with all applicable State codes relating to fire and safety in lieu of compliance with the fire and safety requirements promulgated under paragraph (9), if he determines that such State has in effect fire and safety codes, imposed by State law, which adequately protect patients.".

CERTIFICATION AND UTILIZATION REVIEW BY PODIATRISTS

SEC. 13. (a) Section 1861(r)(3) of the Social Security Act is amended to read as follows: "(3) a doctor of podiatric medicine for the purposes of subsection (s) of this section but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them; and for the purposes of subsections (k) and (m) of tihs section and sections 1814(a) and 1835 but only if his performance of functions under subsections (k) and (m) and sections 1814(a) and 1835 is consistent with the policy of the institution or agency with respect to which he performs them and with the functions which he is legally authorized to perform,".

(b) Section 1861(k)(2)(A) of such Act is amended by inserting after "two or more physicians" the following: "(of which at least two must be physicians described in subsection (r)(1) of this section)".

PHYSICIAN TREATMENT PLAN FOR SPEECH PATHOLOGY

SEC. 14. Section 1835(a)(2)(D)(ii) of the Social Security Act is amended by inserting after "established" the following: "by physician or by the speech pathologist providing such services".

PAYMENT FOR PHYSICIANS' SERVICES WHERE BENEFICIARY HAS DIED

SEC. 15. (a) Section 1870(f) of the Social Security Act is amended to read as follows:

"(f) If an individual who received medical and other health services for which payment may be made under section 1832(a)(1) dies, and no assignment of the right to payment for such services was made by such individual before his death, and payment for such services has not been made—

"(1) if the person or persons who furished the services agree that the reasonable charge is the full charge for the services, payment for such services shall be made to such person or persons, and

"(2) if the person or persons who furnished the services do not agree that the reasonable charge is the full charge for the services, payment for such services shall be made on the basis of an itemized bill to the person who has agreed to assume the legal obligation to make payment for such services and files a request for payment (with such accompanying evidence of such legal obligation as may be required in regulations),

but only in such amount and subject to such conditions as would be applicable if the individual who received the services had not died.".

(b) The amendment made by this section shall apply only to claims filed on or after the date of the enactment of this Act.

PRESUMED COVERAGE PROVISIONS

SEC. 16. (a) Section 1814 of the Social Security Act is amended by striking out subsections (h) and (i) and by redesignating subsection (j) as subsection (h).

(b) Section 1814(c) of such Act is amended by striking out "subsection (j)" and inserting in lieu thereof "subsection (h)".

PAYMENT TO PROVIDERS OF SERVICES

SEC. 17. (a) Section 1814(b) of the Social Security Act is amended to read as follows:

"(b) The amount paid to any provider of services with respect to services for which payment may be made under this part shall, subject to the provisions of section 1813, be the reasonable cost of such services, as determined under section 1861(v) and as further limited by section 1881(b)(2)(B).".

(b) Section 1833(a) of such Act is amended by striking out paragraphs (2) and (3) and inserting in lieu thereof the following:

"(2) in the case of services described in section 1832(a)(2) (except those services described in subparagraphs (D), (E), (F), and (G) of such section and in paragraph (5) of this subsection)—

"(A) with respect to home health services, the reasonable cost of such services, as determined under section 1861(v);

"(B) with respect to other services (except those described in subparagraph (C) of this paragraph), the reasonable costs of such services, as so determined, less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such other services exceed 80 percent of such costs;

"(C) with respect to services described in the second sentence of section 1861(p), 80 percent of the reasonable charges for such services;

"(3) in the case of services described in subparagraphs (D), (E), and (F) of section 1832(a)(2), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may

charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services exceed 80 percent of such costs; and

"(4) in the case of facility services described in subparagraph (G) of section 1832(a)(2), the applicable amount described in subparagraph (A) of section 1833(i)(2); and

"(5) in the case of preadmission diagnostic services described in section 1861(s)(2)(C) which are furnished to an individual by the outpatient department of a hospital within 7 days of such individual's admission to the same hospital as an inpatient or (to the extent practicable as determined by regulations prescribed by the Secretary) to another hospital, the reasonable costs of such services.".

(c) The amendments made by this section shall apply to services furnished on or after January 1, 1980.

LIMIT ON PREMIUM INCREASES DUE TO LATE ENROLLMENT

SEC. 18. The first sentence of section 1839(d) of the Social Security Act is amended by inserting the following immediately before the period at the end thereof: "; except that in no case may the total amount of such increase exceed 30 percent of such monthly premiums so determined".

REENROLLMENT AND OPEN ENROLLMENT IN PART B

SEC. 19. (a) Subsection (b) of section 1837 of the Social Security Act is repealed.

(b)(1) Subsection (e) of section 1837 of such Act is amended to read as follows:

"(e) There shall be a general enrollment period which is any period after the period described in subsection (c).".

(2) Subsection (g)(3) of such section is amended by striking out "the earlier of the then current" and all that follows through "subsection (e) of this section)" and inserting in lieu thereof "the month in which the individual files an application establishing such entitlement".

(c)(1) Section 1838(a)(2)(E) of such Act is amended by striking out "the July 1" and inserting in lieu thereof "the first day of the third month".

(2) The second sentence of subsection (d) of section 1839 of such Act is amended by striking out "who enrolls for the second time) (2)" and all that follows though "in which he enrolled for the second time" and inserting in lieu thereof "who reenrolls) (2) the months which elapsed between the date of termination of a previous enrollment and the date of the subsequent reenrollment".

CHIROPRACTORS' SERVICES

SEC. 20. (a) Section 1861(r)(5) of the Social Security Act is amended by striking out "demonstrated by X-ray to exist" and inserting in lieu thereof "demonstrated by X-ray or other chiropractic clinical findings to exist".

(b) Section 1861(s)(3) of such Act is amended by inserting "(A)" after "(3)", and by adding the following new subparagraph at the end thereof:

"(B) diagnostic X-ray tests which are furnished by a physician described in subsection (r)(5) and which are reasonable and necessary in the diagnosis of a subluxation of the spine;".

INCREASE IN OUTPATIENT MENTAL HEALTH BENEFITS UNDER PART B

SEC. 21. (a)(1) Section 1833(c) of the Social Security Act is amended—

(A) by striking out "there" and inserting in lieu thereof "not more than $937.50"; and

(B) by striking out everything after "subsections (a) and (b)" and inserting in lieu thereof a period.

(2) Section 1866(a)(2)(A) of such Act is amended by striking out the last sentence.

(3) The amendments made by this subsection apply to expenses incurred in calendar years beginning after the date of the enactment of this Act.

(b)(1) Section 1861(r) of such Act is amended by striking out "or" at the end of clauses (3) and (4) of the first sentence and by inserting the following

before the period at the end of the first sentence: ", or (6) a clinical psychologist who is licensed as such by the State (or in a State which does not license clinical psychologists as such, is legally authorized to perform the services of a clinical psychologist in the jurisdiction in which he performs such services) and who meets uniform minimum requirements prescribed by the Secretary, but only for the purpose of section 1861(s)(1) and section 1835(a)(2)(B)(ii) and only with respect to the treatment of an individual who is not an inpatient of a hospital (as defined in subsection (e) or (f) of this section), was referred to the psychologist by a physician described in clause (1), and is receiving such services in connection with the treatment of mental, psychoneurotic, or personality disorders and only with respect to services which such clinical psychologist is legally authorized to perform by the State or jurisdiction in which such services are furnished".

(2) Section 1835(a)(2)(B) of such Act is amended—

(A) by inserting "(i)" before "in the case of";

(B) by striking out "and" at the end thereof; and

(C) by adding the following at the end thereof:

"(ii) in the case of services furnished by a physician described in section 1861(r)(6) to an individual described in such section, such services are or were required for the treatment of mental, psychoneurotic, or personality disorders;".

LIMITATION ON PAYMENTS TO RADIOLOGISTS AND PATHOLOGISTS

SEC. 22. (a) Subsections (a)(1)(B) and (b)(2) of section 1833 of the Social Security Act are each amended by inserting after "pathology" the following: "who has in effect an agreement with the Secretary by which the physician agrees to accept an assignment (as provided for in section 1842(b)(3)(B)(ii)) for all physicians' services furnished by him for hospital inpatients enrolled under this part".

(b) The amendments made by subsection (a) shall apply to services furnished after the sixth calendar month beginning after enactment of this Act.

SHORTENED PART B TERMINATION PERIOD FOR CERTAIN INDIVIDUALS WHOSE PREMIUMS MEDICAID HAS CEASED TO PAY

SEC. 23. (a) Section 1843(e) of the Social Security Act is amended by adding at the end thereof the following: "The coverage period under this part of any such individual who (in the last month of his coverage period attributable to the State agreement or in any of the following six months) files notice that he no longer wishes to participate in the insurance program established by this part, shall terminate at the close of the month in which the notice is filed.".

(b) The second sentence of section 1838(b) of such Act is amended by inserting "(except as otherwise provided in section 1843(e))" after "shall".

(c) Section 1843(g)(2) of such Act is amended—

(1) by adding "and" at the end of clause (A);

(2) by striking out ", and" at the end of clause (B) and inserting in lieu thereof a period; and

(3) by striking out clause (C).

(d) The amendments made by this section apply to notices filed after the third calendar month beginning after the date of the enactment of this Act.

(e) The coverage period under part B of title XVIII of the Social Security Act of an individual whose coverage period attributable to a State agreement under section 1843 of such Act is terminated and who has filed notice before the end of the third calendar month beginning after the date of the enactment of this Act that he no longer wishes to participate in the insurance program established by part B of title XVIII shall terminate on the earlier of (1) the day specified in section 1838 without the amendments made by this section, or (2) (unless the individual files notice before the day specified in this clause that he wishes his coverage period to terminate as provided in clause (1)) the day on which his coverage period would terminate if the individual filed notice in the fourth calendar month beginning after the date of the enactment of this Act.

OUTPATIENT PHYSICAL THERAPY SERVICES

SEC. 24. (a) Section 1833(g) of the Social Security Act, as added by section 251(a)(2) of Public Law 92–603, is amended by striking out "$100" and inserting in lieu thereof "$500".

(b) Subsection (g) of section 1833 of such Act, as added by section 279(b) of Public Law 92–603, is redesignated as subsection (h).

MEDICARE COVERAGE OF PNEUMOCOCCAL VACCINE AND ITS ADMINISTRATION

SEC. 25. (a)(1) Section 1861(s) of the Social Security Act is amended—

(A) by redesignating paragraphs (10) through (13) as paragraphs (11) through (14), respectively;

(B) by striking out "and" at the end of paragraph (8);

(C) by striking out the period at the end of paragraph (9) and inserting in lieu thereof "; and"; and

(D) by inserting after paragraph (9) the following new paragraph:

"(10) pneumococcal vaccine and its administration.".

(2) Section 1864(a) of such Act is amended by striking out "paragraphs (10) and (11) of section 1861(s)" and inserting in lieu thereof "paragraphs (11) and (12) of section 1861(s)".

(3) Section 1862(a) of such Act is amended—

(A) by inserting ", or, in the case of items and services described in section 1861(s)(10), which are not reasonable and necessary for the prevention of illness" before the semicolon at the end of paragraph (1), and

(B) by inserting "(except as otherwise allowed under section 1861(s)(10) and paragraph (1))" in paragraph (7) after "immunizations".

(b)(1) Section 1833(a) of such Act (as amended by sections 17(b) and 30(a) of this Act) is amended—

(A) by striking out "and" before "(F)" in paragraph (1);

(B) by inserting at the end of paragraph (1) the following: "and (G) with respect to items and services described in section 1861(s)(10), the amounts paid shall be 100 percent of the reasonable charges for such items and services, and";

(C) by inserting "and to items and services described in section 1861(s)(10)" in paragraph (2)(A) after "home health services"; and

(D) by inserting "(other than for items and services described in section 1861(s)(10))" after "but in no case may the payment for such services".

(2) The first sentence of section 1833(b) of such Act is amended by inserting "(A)" in clause (2) after "expenses incurred for", and by inserting before the comma at the end of such clause the following: ", or (B) for items and services described in section 1861(s)(10)".

(3) Subparagraph (A) of section 1861(aa)(1) of such Act is amended by inserting before the comma at the end the following: "and items and services described in section 1861(s)(10)".

(c) The amendments made by this section shall apply to services furnished on or after July 1, 1980.

MEDICARE PAYMENT LIABILITY SECONDARY IN CERTAIN AUTOMOBILE INSURANCE CASES

SEC. 26. Section 1862(b) of the Social Security Act is amended—

(1) by inserting "or under an automobile insurance policy" before the period at the end of the first sentence thereof; and

(2) by inserting "or policy" before the period at the end of the second sentence thereof.

HOSPITAL TRANSFER REQUIREMENT FOR SKILLED NURSING FACILITY COVERAGE

SEC. 27. Section 1861(i) of the Social Security Act is amended—

(1) by striking out "14 days" each place it appears therein and inserting in lieu thereof "30 days"; and

(2) by striking out ", or (B) within 28 days" and all that follows through "he resides, or (C)" and inserting in lieu thereof ", or (B)";

OUTPATIENT SURGERY

SEC. 28. (a) Section 1832(a) of the Social Security Act is amended by adding the following new subparagraph at the end of paragraph (2) after the new subparagraphs added by sections 7(a) and 8(a) of this Act:

"(G) facility services furnished in connection with surgical procedures specified by the Secretary pursuant to section 1833(i)(1) and performed in an ambulatory surgical center (which meets health, safety, and other standards specified by the Secretary in regulations).".

(b) Section 1833 of such Act is amended by adding the following new subsection at the end thereof:

"(i)(1) The Secretary shall, in consultation with the National Professional Standards Review Council and appropriate medical organizations, specify surgical procedures which are appropriately (when considered in terms of the proper utilization of hospital inpatient facilities) performed on an inpatient basis in a hospital but which also can be performed safely on an ambulatory basis in an ambulatory surgical center or hospital outpatient department.

"(2)(A) The amount of payment to be made for facility services furnished in connection with surgical procedures specified pursuant to paragraph (1) and furnished to an individual in an ambulatory surgical center shall be equal to an amount established by the Secretary with respect to each such procedure which (i) takes into account the costs incurred by such centers, or classes of centers, generally in prividing the services appropriate for the performance of such services, and (ii) takes such costs into account in such a manner which will assure that the performance of the service in such an ambulatory surgical center will result in substantially less amounts paid under this title than would have been paid if the services had been furnished on an inpatient basis. The amount so established shall be reviewed periodically and may be adjusted, when appropriate, to take account of varying conditions in different areas.

"(B) The amount of payment to be made under this part for services (including all pre- and post-operative services) described in paragraphs (1) and (2)(A) of section 1861(s) and furnished in connection with surgical procedures (specified pursuant to paragraph (1) of this subsection) in an ambulatory surgical center or a hospital outpatient department shall be the reasonable charge for such services if the physician accepts an assignment, as provided for in section 1842(b)(3)(B)(ii), with respect to such payment.".

(c) Section 1835(a)(2) of such Act is amended by adding the following new subparagraph at the end thereof after the subparagraphs added by sections 7(e) and 8(b) of this Act:

"(G) in the case of services furnished in connection with surgical procedures, specified pursuant to section 1833(i)(1), in an ambulatory surgical center, such services are or were medically required.".

(d) Section 1861(u) of such Act is amended by inserting "ambulatory surgical center," after "hospital,".

TECHNICAL RENAL DISEASE AMENDMENTS

SEC. 29. (a) Section 1881(c)(4) of the Social Seecurity Act is amended by adding at the end the following sentence: "The Secretary may not find, for purposes of such certification, that the addition or expansion of a facility within a network is not needed if the State health planning and development agency, fully or conditionally designated under title XV of the Public Health Service Act for the State in which the facility is located, has certified under section 1523(a)(4)(B) of such Act that such addition or expansion is needed.".

(b) Section 1881(e) of such Act is amended—

(1) by striking "and" the first time it appears in paragraph (1) and inserting a comma in lieu thereof;

(2) by inserting "and nonprofit entities which the Secretary finds can furnish equipment economically and efficiently," after "renal dialysis facilities," in paragraph (1);

(3) by striking out "such providers and facilities" and inserting in lieu thereof "such providers, facilities, and nonprofit entities"; and

(4) by striking out "or facility will—" in paragraph (2) and inserting in lieu thereof ", facility, or other entity will—".

(c) Section 1881(g) of such Act is amended by striking out "April" each time it appears and inserting in lieu thereof "July".

PREADMISSION DIAGNOSTIC TESTING

SEC. 30. (a) Section 1833(a)(1) of the Social Security Act is amended by striking out "and (E)" and insertining in lieu thereof "(E)", and by inserting the following after "section 1881," at the end of clause (E): "and (F) with respect to expenses incurred for preadmission diagnostic radiological or pathological services for which payment may be made under this part and which are furnished to an individual by the outpatient department of a hospital within seven days of such individual's admission to the same hospital as an inpatient or, to the extent practicable as determined by regulations prescribed by the Secretary, to another hospital by a physician in the field of radiology or pathology who has an agreement in effect with the Secretary by which the physician agrees to accept an assignment (as provided for in section 1842(b)(3)(B)(ii)) for all physicians' services furnished by him for such services to individuals enrolled under this part, the amounts paid shall be equal to the reasonable charges for such services,".

(b) The Secretary of Health, Education, and Welfare shall report to the Congress no later than one year after the date of the enactment of this Act describing the policy which has been developed and is being or will be implemented with respect to the amendments made by subsection (a) of this section and by section 17(b) of this Act as they concern expenses incurred for preadmission diagnostic testing furnished to an individual at a hospital within seven days of an individual's admission to another hospital.

STUDIES AND DEMONSTRATION PROJECTS

SEC. 31. (a) The Secretary of Health, Education. and Welfare (hereinafter in this section referred to as the "Secretary") shall develop and carry out a demonstration project to determine (1) the extent to which the commencement of nutritional therapy in early renal failure, utilizing (but not limited to) controlled protein substances, can retard or arrest the progression of the disease with a resultant substantive deferment of dialysis, and (2) the administrative, financial, and other aspects of making such nutritional therapy generally available as part of the benefits received under title XVIII of the Social Security Act.

(b) The Secretary shall submit to the Congress, within one year after the date of the enactment of this Act, a report on the demonstration projects being conducted by the Secretary with respect to waiving the applicable cost sharing amounts which beneficiaries under title XVIII of the Social Security Act have to pay for obtaining a second opinion on having surgery performed. Such report shall include any recommendations for legislative changes in such title which the Secretary finds desirable as a result of such demonstration projects.

(c) The Secretary shall conduct a study of the circumstances and conditions under which services furnished by registered dietitians should be covered as a home health benefit under title XVIII of the Social Security Act.

(d) The Secretary shall develop and carry out demonstration projects to determine the administrative, financial, and other aspects of making the services of clinical social workers more generally available as part of the benefits received under title XVIII of the Social Security Act.

(e) The Secretary shall, in consultation with appropriate professional organizations, conduct a comprehensive study of methods for providing coverage under part B of title XVIII of the Social Security Act for orthopedic shoes for individuals with disabling or deforming conditions who require special fitting considerations to help protect against increasing disability or serious medical complications or who require special shoes in conjunction with the use of an orthosis or foot support. The Secretary shall submit to the Congress, no later than January 1, 1981, a report on the findings of this study and such specific legislative recommendations as is appropriate with respect to the utilization, cost control, quality of care, and equitable and efficient administration of such an extension of coverage.

(f) The Secretary shall conduct a study of the circumstances and conditions under which services furnished with respect to respiratory therapy should be covered as a home health benefit under title XVIII of the Social Security Act.

(g) The Secretary shall conduct a study involving a comprehensive analysis of the cost effects of alternative approaches to improving coverage under title XVIII of the Social Security Act for the treatment of various types of foot conditions.

(h) The Secretary shall submit a report on each of the demonstration projects and studies described in subsection (a), (c), (d), (f), and (g). Each such report shall be submitted within twenty-four months of the date of the enactment of this Act and shall contain any recommendations for legislative changes which the Secretary finds desirable as a result of conducting the demonstration project or study with respect to which the report is submitted.

(i) Grants, payments under contracts, and other expenditures made for studies and demonstration projects under this section shall be made in appropriate part from the Federal Hospital Insurance Trust Fund (established by section 1817 of the Social Security Act) and the Federal Supplementary Medical Insurance Trust Fund (established by section 1841 of the Social Security Act). Grants and payments under contracts may be made either in advance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this section. With respect to any such grant, payment, or other expenditure, the amount to be paid from each of such trust funds shall be determined by the Secretary, giving due regard to the purpose of the experiment or project involved.

PROVIDER REIMBURSEMENT REVIEW BOARD

SEC. 32. Section 1878(f)(1) of the Social Security Act is amended by inserting the following after the second sentence thereof: "Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which such determination is rendered. If a provider of services may obtain a hearing under subsection (a) and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulation relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing.".

ACCESS TO BOOKS AND RECORDS OF SUBCONTRACTORS

SEC. 33. Section 1861(v)(1) of the Social Security Act is amended by adding the following new subparagraph after the subparagraph added by section 2(p) of this Act:

"(H) In determining such reasonable cost, the Secretary may not include any costs incurred by a provider with respect to any service furnished in connection with matters for which payment may be made under this title and furnished pursuant to a contract between the provider and any of its subcontractors which is entered into after the date of enactment of this subparagraph and the value or cost of which is $10,000 or more over a twelve-month period unless the contract contains a clause to the effect that until the expiration of three years after the furnishing of such services pursuant to such contract, the subcontractor shall make available, upon request, to the Secretary or the Comptroller General of the United States (or any of their duly authorized representatives) the contract, and books, documents, and records of such subcontractor that are necessary to verify the nature and extent of such costs.".

I. PURPOSE AND LEGISLATIVE BACKGROUND OF THE BILL

The purpose of this legislation is to make various benefit changes and administrative improvements in the Medicare program. Experience with Medicare has indicated that changes are needed to encourage

use of alternatives to institutional care, to allow use of a wider range of providers, and to provide an emphasis in the program on preventive care.

This bill is designed to make Medicare a more effective program to meet the health care needs of the elderly and disabled in an appropriate and cost-effective manner.

H.R. 3990 was introduced on May 8, 1979. It was the subject of hearings and action by the Committee on Ways and Means. The Subcommitte on Health and the Environment considered the bill and amendments thereto and reported it by voice vote with an amendment in the nature of a substitute on February 20, 1980. It was considered by the Committee on Interstate and Foreign Commerce on February 27, 1980, and the full Committee ordered it reported with amendments, by voice vote on March 4, 1980.

II. Summary of the Bill

As approved by the Committee on Interstate and Foreign Commerce, H.R. 3990 would provide for a number of improvements in medicare benefits including liberalization of the home health benefit; elimination of the second waiting period for reentitled disability beneficiaries; coverage for services furnished in community mental health centers and outpatient rehabilitation facilities; and coverage of the cost of pneumoccocal vaccine and its administration. Among other changes are benefit improvements relating to services furnished by dentists, optometrists, chiropractors, and physical therapists.

The Committee's bill also includes provisions which would improve the administration of the medicare program and reduce its cost without loss of protection for beneficiaries. The Secretary would be provided authority to seek reimbursement from private insurance carriers where there is liability for services incurred as a result of an auto accident for example. The bill would also direct the Secretary to establish additional standards and requirements for home health agencies. In addition, a number of minor provisions in the medicare law relating to administration and enrollment have been modified or, where found to be no longer necessary, eliminated.

A summary of the provisions of the bill follows.

HOME HEALTH SERVICES (SECTION 2)

Since the beginning of the medicare program, home health benefits have been available under both part A—hospital insurance—and part B—medical insurance.

To be eligible for home health care, the beneficiary must be: (1) essentially confined to his home, (2) under the care of a physician, and (3) in need of skilled nursing care, speech therapy, or physical therapy. If all these requirements are met, an individual is eligible for the full range of home health services.

The bill would liberalize the medicare home health benefit in the following manner: (1) unlimited visits would be available under both parts A and B; (2) the present three-day prior hospitalization requirement under part A would be eliminated; (3) home health benefits under part B would no longer be subject to the $60 deductible;

(4) the need for occupational therapy would be included as one of the qualifying criteria for the home health benefit; and (5) the present requirement that proprietary home health agencies can participate in medicare only in those States that license home health agencies would be eliminated. In addition, the bill would establish additional standards and reimbursement guidelines for the effective administration of the home health benefit.

Elimination of the limits on the number of visits under parts A and B.—Beneficiaries are presently eligible for 100 visits per benefit period during the year following a hospital stay of at least three days under part A and 100 visits per calendar year under part B. Your Committee's bill would eliminate the limitation on visits under each part.

Elimination of the three-day prior hospitalization requirement under part A.—In order to receive home health benefits under part A, beneficiaries must be hospitalized for at least three consecutive days. Elimination of this requirement would be particularly helpful to the more than 1.1 million beneficiaries who have only part A of medicare; presently they do not have access to the home health benefit unless they have met this prior hospitalization requirement.

Elimination of the part B $60 deductible with respect to home health services.—In 1972, legislation was enacted which exempted the part B home health benefit from the 20-percent coinsurance applicable to other part B services. Elimination of the part B $60 deductible with respect to such services would eliminate the remaining patient cost-sharing on home health services.

Addition of the need for occupational therapy as one of the criteria qualifying a beneficiary for home health benefits.—Under present law, only the need for skilled nursing care or speech or physical therapy qualifies a beneficiary for home health benefits; occupational therapy services are available as a home health benefit only after the beneficiary has otherwise qualified. Occupational therapy, like physical therapy or speech therapy, is a skilled health service which assists a patient who is recovering from an illness or injury in making the transition between an institution and self-care in the home. Accordingly, the Committee's bill recognizes occupational therapy as the fourth skilled service which will qualify beneficiaries for the home health benefit.

Elimination of the licensing requirement for proprietary home health agencies.—By law, proprietary, or for-profit, home health agencies are eligible to participate in the medicare program only where the agency is licensed pursuant to State law and meets such additional standards and requirements as may be prescribed in regulations. Since only 24 States presently license home health agencies, there are a number of States in which proprietary agencies are precluded from participating in the medicare program. With respect to additional standards which by law may be imposed on proprietary home health agencies, it is required that such agencies offer skilled nursing services and one other therapeutic service directly, whereas public and nonprofit agencies are allowed to contract for either the skilled nursing service or the other therapeutic service. This provision would eliminate the special licensing requirement under medicare pertaining to proprietary home health agencies and the authority of the

Secretary to establish additional standards solely on the basis of the tax status of the agency. It should be noted that the provision of current law that requires that home health agencies must meet the applicable parts of State or local law would continue to remain in effect.

In addition to the liberalizations in the home health benefit, the Committee's bill also includes several provisions to assure the more efficient and economical administration of the benefit.

Regional intermediaries for home health agencies.—The Committee bill requires the Secretary to establish regional intermediaries for home health agencies. There has been a wide variation in administrative and reimbursement practices among intermediaries with respect to home health providers. This is largely attributable to the small proportion of an intermediary's medicare business that is devoted to this particular type of provider. As a consequence, little expertise is developed in this area and there is no way of making meaningful comparisons of the utilization and cost of various agencies. Consolidation of the medicare home health business among a smaller number of intermediaries would enable intermediaries to focus more resources on the administration of the benefit and develop uniform cost and performance criteria.

The Committee's bill provides that, in the case of those hospital-based home health agencies which use the same medicare intermediary used by their affiliated hospital, the Secretary is to reassign the home health agency to another intermediary only where he determines such a reassignment would result in more effective and efficient administration of the program.

Home health aides.—The Committee bill modifies the present provision of the home health benefit which covers services furnished by a home health aide on a part-time or intermittent basis by requiring that such aides meet certain qualification standards. It has come to the attention of the Committee that, in some cases, aides have been used to provide services under the medicare home health benefit who have no prior training or experience in caring for the medical needs of the aged and disabled. This has been found to be particularly true in the case of some agencies which do not directly employ home health aides, but contract out for those services, sometimes with personnel agencies which supply general temporary help. The Committee bill makes it clear that home health aides, whether employed directly by the home health agency or made available through contract with another entity, must have completed a training program approved by the Secretary.

Physician certification.—The Committee bill requires that the physician who performs the required certification with respect to home health services and establishes and reviews the plan of treatment cannot be a physician who has a significant ownership interest in or a significant financial or contractual relationship with the home health agency that is providing the service to the medicare beneficiary.

The Committee has found that some home health agency patients have had their certifications or plans of treatment signed and authorized by physicians who are medical directors or owners of the provider home health agencies. The Committee bill would prevent potential conflicts of interest from arising as part of the certification and plan of treatment process.

Bonding and escrow requirements.—In settling the medicare cost reports after the close of a home health agency's fiscal year, it is sometimes determined that in making interim payments throughout the year the medicare program has substantially overpaid the agency. Since home health agencies are generally established with very little capital investment and have little or no equity, there may be no financial resources available to repay the medicare program. For example, in the case of an agency which serves only medicare beneficiaries, the agency can borrow funds to repay the overpayment and medicare will reimburse the agency for 100 percent of the costs related to the loan. The Committee's bill provides the Secretary with authority to establish bonding and escrow requirements for such agencies in order to assure the availability of funds to repay any overpayments. Medicare would not recognize as allowable costs for reimbursement purposes any costs which are incurred in connection with meeting the bonding requirement or establishing an escrow account. To assure that the restricted funds are used to make the repayments, medicare would not recognize as allowable costs, any costs or interested charges incurred in connection with amounts borrowed for the purpose of repaying overpayments. (This limitation on borrowing expenses would apply only to agencies subject to the bonding and escrow requirements.) The Committee recognizes, however, that the amounts available from the bond or the escrow account may not be sufficient to repay the entire amount of the overpayment. In cases where the restricted amounts are used but are insufficient, the borrowing costs would be recognized as allowable costs, to the extent they are reasonable.

Limitations on reimbursement for certain types of contracts.—The bill provides that, in the case of contracts entered into after the date of enactment under which services are furnished for or on behalf of the agency, no costs incurred by the agency in connection with such a contract would be considered allowable costs if either (i) the term of the contract exceeds five years, or (ii) the amount payable under the contract is based on a percentage of the agency's reimbursement for services furnished.

The General Accounting Office has concluded that long-term contracts, as long as—20 to 30 years—which typically provide for management consulting services, are a source of abuse in the medicare program. Similarly, franchise operations have been identified which base their fees on a percentage of reimbursement, with the result that payment under the contract may be considerably more than the actual value of the services furnished. This provision would require the home health agencies to follow normal prudent business practices and assure that the program would not have to pay excessive costs.

With respect to existing percentage-of-reimbursement contracts for services, the Committee's bill would limit medicare reimbursement to amounts which are equal to the reasonable value of the service. In adapting these limitations on reimbursement for existing percentage contracts of home health agences, the Committee intends in no way to diminish any of the Secretary's authority, under current law, to impose limitations on the costs that will be recognized as allowable with respect to contracts entered into by providers of services.

Other administrative requirements.—The Committee bill authorizes the Secretary to establish such other administrative requirements for home health agencies as she finds necessary for the effective and efficient operation of the program.

ELIMINATION OF THE SECOND WAITING PERIOD FOR REENTITLED DISABILITY BENEFICIARIES (SECTION 3)

Under the Committee's bill, entitlement to medicare benefits would be provided for individuals who have been entitled to disability payments for a total of 24 months, regardless of whether those 24 months were consecutive. In that way, an individual who has satisfied the 24-month requirement and attempts unsuccessfully to return to work would be immediately entitled to medicare benefits. Medicare coverage would also be extended for an additional 36 months to disability beneficiaries who return to substantial gainful work.

Medicare protection is provided for individuals after they have been receiving social security cash benefits on the basis of disability for 24 consecutive months. Should a beneficiary recover sufficiently to engage in gainful employment, his disability cash benefits and his medicare coverage are terminated. If the individual becomes disabled a second time within 5 years, he immmediately regains entitlement to cash disability benefits, but under current law he must once again satisfy the 24-month waiting period requirement to qualify for medicare protection.

The purpose of eliminating a second 24-month waiting period for reentitlement to medicare benefits and providing an extended period of entitlement to such benefits for those who return to work, is to encourage disabled persons to attempt to return to work if their conditions improve, without fear of forfeiture protection against medical expenses. Moreover, there is concern that the waiting period provision works an undue hardship on those individuals who try, but are unsuccessful, in their attempts to return to gainful employment.

REPORT ON COVERAGE OF MEDICARE BENEFICIARIES OUTSIDE THE UNITED STATES (SECTION 4)

The Committee's bill requires the Secretary to study the desirability and feasibility of providing Medicare coverage for persons who are overseas.

Under present law, medicare coverage is provided, with a few limited exceptions, only for health care services rendered within the United States. These exceptions cover only cases in which the beneficiary needs emergency hospital services while traveling in Canada between the 48 contiguous states and Alaska; or needs hospital services because of a medical problem that arose while traveling or residing within the United States near the border, and a Canadian or Mexican hospital is more accessible than the nearest United States hospital. This limitation on medicare coverage was included in the law because of the administrative problems involved in verifying the medical necessity for services furnished outside the United States, establishing the qualifications of foreign medical practitioners and institutions,

and determining the appropriate amount of payments to make for services.

Concern has been expressed that limiting coverage in this way deprives persons who would otherwise be entitled to Medicare from adequate health care coverage when out of the country. Balanced against this concern, however, are questions of the appropriate way to extend coverage, the potential cost involved, the effect on balance of payments, and concerns as to whether arrangements with other countries should involve reciprocal agreements to provide coverage for foreign nationals while in the United States. Because of these concerns, the Committee did not recommend authorizing the President to enter into reciprocal agreements at this time.

As part of the study mandated in the Committee bill, the Secretary would be required to report on the potential number of persons who do not receive Medicare benefits because they are outside the United States and the costs that would be involved in providing coverage for them. The Committee seeks information on the administrative problems that would need to be solved to provide these benefits, the views of the Department on the most feasible and appropriate arrangements with other countries to carry this out, the arguments for and against limiting coverage only to emergency services for persons overseas and the feasibility of providing coverage for persons overseas both with and without entering into reciprocal agreements to provide foreign nationals with coverage in the United States.

The Secretary is required to report back to the Congress within one year of the date of enactment of this bill.

DENTISTS' SERVICES (SECTION 5)

The bill would modify present law to cover services performed by dentists where those services are presently covered when performed by physicians. The bill would also cover hospital stays for the performance of noncovered dental services where the severity of the dental procedure warrants hospitalization.

Under present law, services furnished by dentists are covered under part B of medicare but only with respect to: (1) Surgery of the jaw or any structure contiguous to the jaw, or (2) reduction of any fracture of the jaw or facial bone. Payment for routine dental services is specifically excluded. However, there are some services which are regularly performed by both physicians and dentists but which are covered under medicare only if performed by a physician. For example, certain procedures and services relating to treatment of oral infections are covered when furnished by a physician but are not covered when furnished by a dentist. Such functions do not involve routine dental care, which is separately excluded under existing law whether performed by a dentist or a physician. It is appropriate to provide the same coverage for services performed by a dentist (which are within the scope of his state license) that is provided for services performed by physicians. The present exclusion of routine dental services would remain in effect.

The Committee also concluded that present coverage for inpatient hospital services related to certain noncovered dental procedures is inadequate. Under existing law, the test for medicare coverage of the inpatient services is the patient's underlying condition (e.g., history of heart failure). As a result, hospitalization coverage is precluded where, in the judgment of the patient's dentist, the severity of the dental procedure alone requires hospitalization. Accordingly, the bill would cover hospital stays based on a dentist's (or physician's) certification that hospital inpatient services are necessary for the performance of noncovered dental procedures either because of the severity of the dental procedure or the patient's underlying condition warrants such hospitalization.

TREATMENT FOR PLANTAR WARTS (SECTION 6)

The committee's bill would eliminate the present exclusion of services related to treatment of plantar warts.

Under present law, coverage for services related to routine foot care—which is defined as "including the cutting and removal of corns, warts, or calluses, trimming of nails, and other routine hygienic care"—is specifically excluded.

Warts on the feet (often called plantar warts because they may appear on the plantar surface of the foot), are tumors caused by infectious viral agents. However, because of the routine foot care exclusion in present law, treatment for plantar warts is not a covered service, while the treatment of warts located elsewhere on the body is a covered service. The committee bill therefore eliminates this inconsistency in present law by removing the present exclusion on coverage of services related to the treatment of plantar warts.

COMMUNITY MENTAL HEALTH CENTERS (SECTION 7)

The bill provides that services furnished in qualified community mental health centers would be reimbursed under part B of medicare on a cost-related basis or on the basis of other tests of reasonableness as are determined by the Secretary to be appropriate. Up to fifteen outpatient visist per year would be covered and up to 60 partial hospitalization visits per year would be covered.

Community mental health centers are not specifically recognized under present law. Services furnished by a community mental health center which is physician-directed are presently covered either as physicians' services or services furnished "incident to" a physician's services (e.g., services of psychologists and other professionals). Services furnished in community mental health centers which are not physician-directed are not generally covered under the medicare program.

Since 1963, the Federal Government has been involved in efforts to develop community mental health centers which offer a range of outpatient mental health services in the expectation that such centers would replace large inpatient institutions as the primary place of treatment for the mentally ill. The current medicare limitations on the

coverage of outpatient mental health services are not consistent with this larger objective.

The committee recognizes that there are differences within the health care community as to the strict applicability of the medical model to the diagnosis and treatment of mental disorders. Thus, while standard medicare terminology may be used for definitional purposes in the bill, this terminology should be understood and applied within the framework of accepted prevailing practices followed by qualified community mental health centers in the provision of mental health services. It is also the intent that periodic review and approval of a plan of treatment be conducted by a center's duly constituted treatment review committee, of which the physician is a member, composed of members of the several disciplines involved in the care and treatment of the patient. In addition, while the physician certification with respect to partial hospitalization visits must include a judgment as to the patient's need for institutionalization in the absence of partial hospitalization visits, it is not the intent that such a judgment need imply that institutionalization would otherwise be required immediately.

The use of the term "diagnostic and therapeutic services" in the definition of covered community mental health services is intended to encompass those liaison and coordination services furnished by qualified mental health personnel of the center as part of the overall management of patient care. Qualified mental health professionals, for purpose of determining Medicare reimbursement are, in addition to the physician, clinical psychologists, psychiatric nurses, and psychiatric social workers who meet standards established by the Secretary of Health, Education and Welfare. The Committee bill defines (in Section 21) a qualified clinical psychologist as one who is licensed in the State or, in a State which does not license clinical psychologists, is legally authorized to perform the services of a clinical psychologist, and who meets such other requirements as are determined necessary by the Secretary. It is the Committee's intent that a qualified clinical psychologist would be further defined by the Secretary as one who has a doctorate degree in psychology, and has had at least two years of supervised clinical experience in an organized setting, such as a hospital which has an accredited mental health facility or a Federally-qualified community mental health center, or who has a comparable combination of education and clinical experience. The Committee expects that the Secretary would determine a qualified psychiatric social worker to be one who is licensed by the State where a State has a licensure program, who has a masters' degree from an accredited school of social work, and who has two years of supervised clinical experience. Further, the Secretary would be expected to define a qualified psychiatric nurse to be one who is licensed to practice nursing by the State in which he or she functions, who has a masters degree in psychiatric nursing or a related field from an accredited educational institution, and who is certified as a psychiatric nurse by the appropriate certifying body (if any).

The term "under the case management of a physician" in the community mental health center setting is used to emphasize that daily, "over-the-shoulder" supervision by a physician of all of the services

furnished by the center is not appropriate. Case management is intended to imply a process through which a physician and qualified mental health professionals collaborate in order to ensure equality of patient care and treatment. Case management requires that the physician monitor and evaluate all medicare patients, be available for advice and consultation as needed, and provide direction and supervision to the qualified mental health professionals concerning the medical services to be provided. This process may take place apart from the direct service contact of the qualified mental health professional. This process must also be regularly scheduled, depending upon the patient's condition, and documented in the patient's record.

The Committee's bill extends recognition as qualified providers only to those centers meeting the definition of and requirements for a community mental health center contained in the Community Mental Health Center Act and the regulations prescribed thereunder. However, the bill directs the Secretary to develop comparable standards, in consultation with appropriate professional organizations, (including the Joint Commission on Accreditation of Hospitals), for the possible future coverage of other outpatient mental health centers, and to submit to the Congress such recommendations as she finds appropriate with respect to coverage and standards for such centers. Such recommendations are to be submitted within 24 months after enactment.

COMPREHENSIVE OUTPATIENT REHABILITATION CENTERS (SECTION 8)

Comprehensive outpatient rehabilitation centers would be recognized under the committee's bill as providers of services under medicare. Such rehabilitation centers could be public or private institutions primarily engaged in providing under medical direction diagnostic, therapeutic, and restorative services to outpatients and would be required to meet specified conditions of participation.

Under present law, medicare covers certain rehabilitation services in a variety of settings under various coverage provisions. Such services are included among the services that may be reimbursed on a charge basis as "incident to" the services of a physician. Outpatient physical therapy and outpatient speech pathology services are covered on a cost-related basis when furnished by a clinic, rehabilitation agency or public health agency; however, this coverage provision does not include occupational therapy and other rehabilitation services. Services furnished by an independently practicing physical therapist in the office setting are also covered, but there is an annual limit on the amount medicare will pay for such services.

Present law does not provide coverage for a broad array of rehabilitation services where these are furnished on an outpatient basis in a coordinated fashion by a comprehensive outpatient rehabilitation facility. The committee's bill would make provision for such coverage, including the coverage of occupational therapy, by recognizing such facilities as providers of services if they meet specified conditions of participation and by providing reimbursement under part B for the services ordinarily furnished by such facilities based on the costs they incur in furnishing covered services to medicare beneficiaries.

OPTOMETRISTS' SERVICES (SECTION 9)

The Committee's bill would provide coverage for the services of optometrists which are related to the condition of aphakia (absence of the natural lens of the eye). Also, the Secretary would be directed to report to the Congress as to specific legislative recommendations for implementing coverage for services furnished by optometrists to cataract or other patients.

Present law specifically excludes payment for eyeglasses, eye examinations for the purposes of prescribing, fitting, or changing eyeglasses, and procedures performed to determine the refractive state of the eye. However, post-surgical lenses for aphakic patients are covered as prosthetic devices when prescribed by a physician or an optometrist. While medicare will cover the cost of a physician's examination to determine the need for the prosthetic lenses, the cost of the same service when furnished by an optometrist is not covered. The only services for which optometrists may be reimbursed under present law are dispensing services in connection with the actual fitting and provision of such prosthetic lenses.

The bill provides for payment under Medicare for examination services performed by optometrists in connection with the condition of aphakia. Optometrists would be reimbursed for such services only if they are licensed to perform them by the State in which they practice. Additionally, as under current law, refractions would not be paid for whether performed by an optometrist or an ophthalmologist.

A study was conducted by the Department of HEW in 1976 to determine the appropriateness of medicare coverage for services furnished by optometrists. The expert consultants to the study concluded that medicare coverage should be extended to those services that an optometrist is legally authorized to perform in connection with the condition of aphakia and cataracts. However, HEW recommended that, while optometrists' services related to aphakia should be covered at the present time, it would be inappropriate to provide coverage for services furnished by optometrists to cataract patients until the Department has had an opportunity to resolve a number of administrative issues related to such matters as delivery pattern changes, utilization controls, an operational definition of cataracts, and cost controls. In light of these considerations, the committee's bill provides for the coverage of optometrists' services related to the condition of aphakia and directs the Secretary to complete his analysis of the pending administrative issues and submit legislative recommendations with respect to medicare reimbursement for optometrists' services for cataract patients.

ANTIGENS (SECTION 10)

The bill would allow payment to an allergist for the preparation of a reasonable supply of an antigen, including a supply forwarded to another physician or a rural health clinic for administration.

Under present law, medicare coverage of drugs and biologicals (including antigens) is limited to those drugs and biologicals which (a) cannot be self-administered, (b) are commonly furnished in physicians' officers incident to a physician's professional service, and

(c) are commonly either rendered without charge or included in the physician's bill. Thus, the cost of antigens can be covered, but only where their preparation and administration is an integral part of the allergist's service and represents an expense to him. The Committee's bill would allow payment to an allergist for the preparation of a reasonable supply of antigens, including a supply forwarded to another physician or a rural health clinic for administration.

In the case of a beneficiary who lives some distance from his allergist, the allergist diagnoses the patient's allergy and prepare an antigen with which to treat it; and often, the patient's family physician performs the actual administration of the antigen. Under present law, however, the cost of the antigen is not covered unless the allergist who prepared the antigen also administers it. This creates a financial hardship for a beneficiary who lives too far from his allergist to travel back and forth for the regular administration of the antigen, since he must pay for the antigen himself. The bill would remedy this problem by allowing payment for the antigen even where the allergist does not administer it.

PAYMENT WHERE BENEFICIARY IS NOT AT FAULT (SECTION 11)

The committee's bill contains a provision requiring the Secretary to make payment where a medicare beneficiary who medically required a higher level of care was erroneously placed in a distinct part of an institution designated to offer a lower level of care.

This provision incorporates without change into the Committee's bill an amendment, recommended by the Committee on Ways and Means, which has jurisdiction over provisions affecting Part A of the Medicare program.

Under the bill, podiatrists, acting within the scope of their practice, travel back and forth for the regular administration of the antigen.

FLEXIBILITY IN APPLICATION OF STANDARDS OF RURAL HOSPITALS (SECTION 12)

The bill authorizes the Secretary to apply medicare standards to rural hospitals more flexibly to take into account the availability of qualified technical personnel, the scope of services furnished, and the economic impact of structural standards which if rigidly applied would result in unreasonable financial hardships for a rural hospital; but only to the extent that such differential application of the standards does not jeopardize or adversely affect the health and safety of patients.

This provision incorporates without change into the Committee's bill an amendment recommended by the Committee on Ways and Means, which has jurisdiction over provisions affecting Part A of the Medicare program.

CERTIFICATION AND UTILIZATION REVIEW BY PODIATRISTS (SECTION 13)

Under the bill, podiatrists, acting within the scope of their practice, would be recognized by medicare for purposes of physician certification and participation as physicians in utilization review. This recog-

nition would be extended where consistent with State law and the policies of the health care institutions involved.

As a condition of payment for hospital and other services covered under medicare, existing law requires that a physician certify as to the medical necessity for the service. Also, medicare requires that the utilization review committee of a hospital or skilled nursing facility include at least two physicians. For neither purpose does a podiatrist qualify as a "physician."

Since medicare covers as "physicians' services" the services performed by podiatrists within the scope of their practice, the committee concluded that medicare should also recognize podiatrists as physicians for purposes of physicians certification and participation in utilization review.

The bill extends this recognition to certification and utilization review activities that are consistent with the functions the podiatrist is legally authorized to perform in the State where he practices, and where this recognition is consistent with the policies of any health care institution that is involved. With respect to utilization review, a podiatrists acting as a physician member of a utilization review committee would not take the place of an M.D. or osteopath as one of the two required physician members of the committee.

PHYSICIAN TREATMENT PLAN FOR SPEECH PATHOLOGY SERVICES (SECTION 14)

The bill would repeal the existing medicare requirement that a physician establish a detailed plan of treatment for speech pathology services.

The Social Security Amendments of 1972 provided for coverage of speech pathology services furnished on an outpatient basis in an organized setting such as a clinic, a rehabilitation agency, or a public health agency. Prior to 1972, outpatient speech pathology services were covered only when furnished by an approved hospital, skilled nursing facility, or home health agency. Present law requires that the patient be referred to the speech pathologist by a physician and that the physician establish and periodically review a plan of treatment which specifies the amount, duration and scope of services to be furnished.

Since speech pathology involves highly specialized knowledge and training, physicians generally do not specify in detail the services needed when referring a patient for such services. As a result, the Committee's bill allows either the physician or the speech pathologist to establish the plan of treatment so as to conform medicare law and related program policy to actual practice among the professions. The requirement for physician referral and periodic physician review of the plan of treatment would be retained.

PAYMENT FOR PHYSICIANS' SERVICES WHERE BENEFICIARY HAS DIED (SECTION 15)

The bill would authorize medicare reimbursement for physicians' services rendered to a medicare patient before his death, on the basis of an unpaid bill, to an individual who has assumed the legal obligation to pay for the physician's services.

Under present law, a beneficiary who has received physician services which are reimbursable under medicare can either; (1) Send medicare an itemized bill, whether paid or unpaid, and be reimbursed directly by the program, or (2) assign the right to receive payment to the physician who provided the service. Where a beneficiary dies before he has executed an assignment of the bill, payment may be made directly to the physician only if he agrees to accept the medicare-determined reasonable charge as payment in full. (He may collect from the beneficiary only the applicable deductible and coinsurance amounts.) If the physician does not agree to this procedure, present law authorizes medicare reimbursement to the estate or the survivors of the deceased beneficiary, but only if the bill has been paid.

The requirement that the physician's bill must be paid (where the assignment method is rejected by the physician) before medicare can make reimbursement often represents a significant financial burden for survivors of the deceased beneficiary. Thus, in cases where a physician does not agree to accept assignment on a claim for payment of services furnished to a deceased beneficiary, the bill would allow payment on the basis of an unpaid bill. Payment would be made only to an individual who presents evidence that he has assumed the legal obligation to pay for the physician's services.

PRESUMED COVERAGE PROVISIONS (SECTION 16)

The bill would repeal existing medicare provisions authorizing, by type of diagnosis, presumed periods of coverage for skilled nursing facility and home health services. Protection against retroactive denials would continue to be afforded by general waiver of liability provision.

The 1972 Social Security amendments directed the Secretary to establish a minimum number of days of care in a skilled nursing facility or visits by a home health agency which would be "presumed" to be covered by type of patient diagnosis. This provision was enacted because skilled nursing facilities and home health agencies were experiencing a high rate of retroactive denials for services they provided on the assumption they would be covered by medicare.

A number of skilled nursing facilities and home health agencies have found the presumed coverage regulations confusing, often mistaking what are minimum days or visits covered as the maximum allowed. And in practice, the regulations carrying out this provision create unnecessary administrative steps for both providers and the program since the problem of retroactive denials has been ameliorated by other means. Another provision of the 1972 amendments—a more general waiver of liability—has turned out to be a more effective remedy and the presumed coverage provisions are no longer needed. According to HEW statistics, claims filed by skilled nursing facilities and home health agencies under the presumed coverage provision now represent less than one-half of one percent of all claims for payment filed by these providers.)

It is the Committee's intention that since the waiver of liability provision is to be used in all cases in this area, it rules are to be applied flexibly so as not to work undue hardship in cases which had been covered under the presumed coverage approach. In particular, it is

intended that care be used in the application of rigid percentage limitations with respect to acceptable denial rates. This is particularly true in the case of those providers of service that have very small numbers of medicare beneficiaries where a denial in one or two cases might have the effect—through strict application of a percentage formula—of denying access to the favorable presumptions embodied in the provision.

PAYMENT TO PROVIDERS OF SERVICES (SECTION 17)

The bill would repeal the existing provisions of the medicare law under which payments to a provider of services are limited to the provider's customary charges if these charges are lower than reasonable costs.

Also, medicare reimbursement to providers of services under part B would be based on reasonable cost minus the coinsurance amounts charged beneficiaries by the provider.

Although medicare providers of services are generally reimbursed, under present law, on the basis of reasonable costs, the amount of payment is limited to the lesser of the reasonable cost of covered services or the provider's customary charges to the public for such services. A variation of this rule applies to "public" (i.e., governmental) providers of services who render services free of charge or at nominal charges to the public; such providers are reimbursed, pursuant to regulations of the Secretary, on a basis that provides fair compensation. The rationale for this lower of costs or charges provision was that it would be inequitable for medicare to pay more for services than the provider charges the general public. However, despite an elaborate set of rules to avoid harsh treatment of certain providers, situations have arisen in which there is a question whether it is good public policy reduce reimbursement, as this provision requires, to levels below cost—for example, in the case of Easter Seal rehabilitation agencies and community-supported home health agencies. Accordingly, the bill would repeal the lower of costs or charges provision.

Under another provision of present law, providers of services are paid 80 percent of the reasonable cost for services covered under medicare part B. Providers are authorized to charge beneficiaries a coinsurance amount equal to 20 percent of the reasonable charges (not in excess of their customary charges) for the services in question. The medicare reimbursement amount and the coinsurance amount are determined without reference to each other. Together, they sometimes produce income to the provider in excess of 100 percent of the reasonable cost. This result would be avoided under the committee's bill, which provides for payment of 80 percent of the reasonable cost only to the extent that this does not exceed the reasonable cost minus the coinsurance.

LIMITS ON PREMIUM INCREASES DUE TO LATE ENROLLMENT (SECTION 18)

The bill would modify the existing provisions that require premiums for medicare part B (and for optional part A coverage) to be increased by ten percent for each year the beneficiary could have been but was

not enrolled by limiting the preimum increase to a maximum of 30 percent.

Under present law, if an individual fails to enroll timely in medicare's medical insurance plan (part B), the otherwise applicable premium amount is increased by 10 percent for each 12 months elapsing between the time he could have enrolled and actually did enroll. A similar premium increase is charged to uninsured persons who do not enroll timely in the hospital insurance plan (part A). There is no limit on the percentage amount the part A or part B premium can be increased due to late enrollment. The purpose of these provisions was to avoid the adverse selection that might occur if substantial numbers of healthy persons delayed enrollment until they were well past age 65 and became ill.

Most people who enroll late do so, not because their health has deteriorated, but for a variety of reasons not related to health. For example, many aged beneficiaries mistakenly believe they have to retire from work before they can enroll and thus enroll long after their initial enrollment period. Others, who are residing outside the country and cannot benefit from part B because of the exclusion of foreign medical care, enroll only upon their return to the United States. Still others decide not to enroll initially because they are covered under their employers' or their spouses' health plan. In many of these cases, the increased premium due to late enrollment could be considerably higher than the expected increase in program costs resulting from late enrollment and, in some cases, could produce a total premium that is prohibitive to persons living on reduced retirement income. The committee bill establishes a 30 percent limit on the amount by which parts A and B premiums can be increased due to late enrollment. Such limit should keep the premium within more affordable reach and yet deter such adverse selection as might still occur.

REENROLLMENT AND OPEN ENROLLMENT IN PART B (SECTION 19)

The Committee's bill would provide for a general, continuous open enrollment period for purposes of enrolling in Part B of Medicare, the Supplementary Medical Insurance Benefits program, and would repeal a provision of existing law that permits an individual to enroll in Part B only once.

Under current law, an individual may enroll in Part B of the Medicare program during an initial enrollment period (which begins three months before the individual becomes 65 and extends for seven months). Under current law, if an individual fails to enroll during his or her initial enrollment period, enrollment is possible only during a general enrollment period, which occurs January 1 through March 31 of each year. Coverage then becomes effective on July 1. This enrollment arrangement can cause hardship for individuals who may be left without medical care coverage for a period of nearly one year until a general enrollment period occurs and the enrollment becomes effective. The Committee's bill replaces the provisions of current law with a continuous general open enrollment period which would allow an eligible individual to enroll at any time, with the coverage effective three months after enrollment.

Under present law, an individual is permitted to reenroll in part B of the program only once; that is, if he disenrolls twice he is permanently barred from participation in the program. While the original purpose of this provision was to prevent the adverse selection that could occur if individuals were permitted to enroll and disenroll at will whenever there was a change in their health condition, the committee has found that beneficiaries do not as a rule disenroll from the program without good reason. But, there have been instances in which individuals through misunderstanding or inadvertence, have barred themselves from the program. Accordingly, the bill allows unlimited reenrollment in part B. Elimination of this part B requirement would also allow unlimited reenrollment under part A.

CHIROPRACTOR'S SERVICES (SECTION 20)

This bill would modify the requirements for chiropractic coverage so that a subluxation could be demonstrated to exist either through X-ray or other chiropractic clinical findings. An X-ray, where taken to diagnose a subluxation, would be covered by medicare.

Under present law, medicare covers only those services of chiropractors which involve treatment of a subluxation (partial dislocation) by means of manual manipulation of the spine. The existence of a subluxation must be demonstrated by X-ray; however, the cost of the X-ray is not covered when performed by a chiropractor.

The X-ray requirement was intended to control costs by excluding from coverage cases in which a subluxation was not evident on an X-ray. The denial rate for claims submitted by chiropractors has been significantly higher than for other providers. However, the General Accounting Office has indicated that the extent to which X-rays play a part in claims denial is not known. Although chiropractors must have X-rays available upon request, the X-ray is actually reviewed by medicare carriers in only a small number of cases.

The Committee believes that the requirement for an X-ray to demonstrate the subluxation of the spine is possibly hazardous, and—since it is not paid for by the program—represents a significant cost to beneficiaries. Since chiropractors would not ordinarily take X-rays in every case to diagnose subluxation of the spine, the Committee has concluded that it is inappropriate to require X-rays, with their accompanying radiation risks, for administrative purposes.

However, the Committee remains concerned about the difficulties which may arise with regard to the verification of claims submitted by chiropractors. In order to exert proper control over the benefits provided under this bill it will be necessary for the Secretary to develop definitions of "subluxation of the spine" and "chiropractic clinical findings" which are precise, workable and scientifically valid. In developing these definitions, the Committee expects that the Secretary would solicit the recommendations of doctors of medicine and osteopathy, particularly those who specialize in the treatment of diseases or conditions of the spine, and of appropriate chiropractic authorities. It will also be necessary for the Secretary to determine when diagnostic X-ray tests are reasonable and necessary in the diagnosis of a subluxation of the spine. The Committee expects the Secretary to

submit periodic reports to this Committee and the Committee on Ways and Means on the experience of the Health Care Financing Administration in administering chiropractic benefits under this section and the need for any further legislative clarification or modification of its provisions.

Finally, because of the financial burden involved for Medicare beneficiaries if they must pay for the X-ray, the Committee bill makes provision for Medicare to pay for an X-ray where it is a necessary part of the chiropractor's diagnosis.

OUTPATIENT MENTAL HEALTH SERVICES (SECTION 21)

The bill would increase reimbursement for outpatient mental health services from the present limit of 50 percent of reasonable charges, up to $250 in actual program payments per year, to 80 percent of reasonable charges, up to $750 in program payments per year. Services furnished by clinical psychologists on an outpatient basis would be covered, subject to the overall limit on outpatient mental health services, where the patient is referred by a physician.

The Committee believes that the present limitation on payment for mental health services, which has been in effect since the enactment of the program in 1965, is no longer realistic because of the substantial increase in the cost of health care services since that time. Increasing the limit on program payment to 80 percent of reasonable charges, up to $750 per year, would substantially increase beneficiary protection.

Outpatient mental health services would also be made more available to the elderly by covering the services of qualified clinical psychologists. The bill defines a qualified clinical psychologist as one who is licensed in the State (or in a State which does not license clinical psychologists, is legally authorized to perform the services of a clinical psychologist) and meets such other requirements determined necessary by the Secretary. As specified for purposes of section 7, it is the Committee's intent that a qualified clinical psychologist would be further defined by the Secretary as an individual who has a doctorate degree in psychology and has had at least two years of supervised clinical experience in an organized setting such as a hospital which has an accredited mental health facility or a Federally-qualified community mental health center, or who has a comparable combination of education and clinical experience. The Committee expects the Secretary to use, to the extent appropriate, the National Register of Health Service Providers in Psychology which has been established under the auspices of the American Psychological Association. In addition, the Committee expects the Secretary to designate further what specialty training within the various areas of applied psychology would be appropriate for providing therapeutic services to medicare beneficiaries.

The Committee bill would cover outpatient services furnished by independently practicing psychologists only where the beneficiary has been referred to the psychologist by a physician. The Committee recognizes that there are conflicting views as to the need for and appropriateness of such a requirement. The Committee believes, however, that such a requirement should be retained until sufficient information

is available to evaluate the effect of its elimination. The Committee expects the Secretary to conduct a study and submit information within one year after the enactment of this provision, which would enable the Committee to judge whether the continuation of the mandated referral by a physician is appropriate. The Committee expects that the Secretary, in conducting the study, will consult with psychiatrists, psychologists, and physicians in the general practice of medicine with respect to whether the requirement is necessary to assure that the beneficiary receives all appropriate medical and mental health services. The Secretary, in his examination of this issue, should also weigh the implication of eliminating the referral requirement on general medicare program policy.

PAYMENTS TO RADIOLOGISTS AND PATHOLOGISTS (SECTION 22)

Under the Committee bill, the special 100 percent reimbursement (with no deductible) for services to hospital inpatients by physicians in the fields of radiology and pathology would be limited to physicians who agree to accept assignment for all services furnished to hospital inpatients.

Currently, radiologists and pathologists are reimbursed 100 percent of the reasonable charge for services furnished to inpatients of a hospital. This occurs whether or not the physician accepts assignment. (In accepting assignment, a physician agrees to accept the medicare reasonable charge as payment in full.) Reimbursement for all other covered physicians' services is subject to a 20 percent coinsurance and a yearly $60 deductible.

The provision entitling radiologists and pathologists to 100 percent of the reasonable charge was adopted in the 1967 Social Security Amendments to permit a simplified hospital and physician combined billing arrangement. At the time it was felt that the amendment was needed because of the practice of some hospitals of submitting combined billings for both the physician's services and the hospital's laboratory and radiology services. The latter are reimbursable under part A and the former under part B. Because deductible and coinsurance amounts for the two parts differed, it was difficult not only to allocate the combined charge between parts A and B in individual bills, but also to subject those allocated charges to separate deductibles. It was anticipated that administrative savings would accrue as a consequence of the combined billing arrangement.

Contrary to that anticipation, many of these physicians bill the patient directly, rather than combining their billings with those of the hospital. As a consequence, the physicians receive the benefit of 100 percent reimbursement without the expected benefit to the beneficiary or the medicare program. (If the physician services are billed for by the hospital, the beneficiary is assured that he will not have to pay any additional amounts. A physician billing the beneficiary directly can charge and demand payment of more than the medicare reasonable charge.)

This provision would require radiologists and pathologists to accept assignment as the quid pro quo for the waiver of the deductible and coinsurance. Physicians refusing to accept assignment for services

provided to medicare inpatients would bill on an unassigned basis, with the medicare program reimbursing the beneficiary for the reasonable charge, less applicable cost-sharing.

The Committee notes that the provision of current law relating to 100 percent reimbursement is applicable only to services to hospital inpatients provided by physicians in the fields of radiology and pathology. Traditionally, the services of radiologists which were reimbursable at 100 percent of reasonable charges were limited to those services which involved the use of x-rays, radium, or radioactive isotopes. However, with recent developments in the field, including the use of ultrasound as a diagnostic tool by both radiologists and physicians of other specialties, some have suggested that services involving ultra sound should be reimburseable at 100 percent of reasonable charges if performed by radiologists, and the Department of Health, Education and Welfare published a notice of proposed rulemaking which set forth such a policy for purposes of comment. The Committee is concerned that differentiating the proportion of the reasonable charge paid for by Medicare depending on the specialty of the physician providing the service could lead to inappropriate effects on the utilization of the service when offered by different medical specialties. Because of its concern, the Committee sought, and has received, assurances from the Health Care Financing Administration that no change will be recommended in the current definition of radiological services that are reimburseable at 100 percent of reasonable charges.

SHORTENED PART B TERMINATION PERIOD WHERE MEDICAID HAS CEASED TO PAY PREMIUMS (SECTION 23)

The Committee bill would permit an individual whose State buy-in covreage for part B of medicare has ended to terminate part B coverage effective with the month in which the Health Care Financing Administration (HCFA) is notified that part B coverage is no longer wanted.

Under present law when State buy-in coverage is terminated, an individual's enrollment in part B is continued automatically unless he or she requests that coverage be terminated. After such a request an individual's coverage may not be terminated until the close of the calendar quarter in which the request is made. This results in the individual's coverage and premium liability continuing for anywhere from 3 to 6 months after the State has ceased its buy-in coverage.

This provision would require States to notify the beneficiary and HCFA of their final decision on or before the effective date the individual's buy-in coverage was terminated (asuming that the State had previouly given the individual prior notification of its intent to terminate and an opportunity for a hearing under the due process provisions). Following the State's notification, HCFA would also be required to notify the beneficiary that State termination of buy-in had occurred.

OUTPATIENT PHYSICAL THERAPY SERVICES (24)

The bill would increase the present $100 limitation on outpatient services furnished by independently practicing physical therapists to $500.

The $100 limitation in present law, initially imposed in the Social Security Amendments of 1972, was intended to help control program expenditures and to reduce the potential for over-utilization of these newly covered services. However, the increases in medical costs since 1972 have resulted in a reduction in the value of the original $100 limit to the extent that this amount now purchases considerably less services. This decline in purchasing power creates serious problems for those beneficiaries who require the services of independently practicing therapists.

In deciding to increase the dollar limitation on reimbursement for physical therapy services provided by private practitioners, the Committee recognizes that as an alternative, a limit could be imposed on the number of patient visits. A visit limit similar in concept to that which has in the past been imposed on home health agencies has the possible benefit of avoiding the need for frequent amendments because of inflation. To assist the Committee in weighing the visit limit alternative in the future, the Secretary has been requested to collect and submit data on the costs of physical therapy services provided by therapists in independent practice. The Committee expects that, in submitting such data, the Secretary would include national comparisons of costs for physical therapy services furnished by independent practitioners and the cost of such services when provided in all other settings covered under the medicare program.

MEDICARE COVERAGE OF PNEUMOCOCCAL VACCINE AND ITS ADMINISTRATION (SECTION 25)

The Committee bill would provide for coverage under the Medicare program of immunizations against pneumococcal pneumonia. Medicare would be authorized to pay for the pneumococcal vaccine and for its administration. In order to encourage utilization of the vaccine, the amendment waives the co-payment and deductibility provisions of existing law.

The Committee bill ends the present incongruous Federal policy under which Medicare is authorized to pay for the treatment of pneumonia in the elderly but is not authorized to pay for vaccinations to prevent it. Pneumonia is the fifth leading cause of death in the United States, with pneumococcal pneumonia accounting for 54,000 deaths annually. Of this number, 48,600 or 90 percent are in the over 65 age population. Yet, the present Medicare law discourages the elderly from taking advantage of a new vaccine that gives highly effective protection against pneumococcal pneumonia, the most widespread of all pneumonias. Because the elderly are particularly susceptible to pneumococcal pneumonia and because they may suffer very serious health consequences if they contract the disease, the Committee feels existing law should be changed.

Current law is shortsighted from a budgetary standpoint as well. The Federal Government pays in excess of $300 million in Medicare payments each year to treat pneumococcal pneumonia cases among the elderly. The Committee believes that by paying for prevention, the Medicare program will reduce these treatment costs substantially. Because of the potential savings in human costs as well as treatment

costs, the Committee expects the Secretary to make an active effort to inform the elderly of the new coverage.

The new provision prohibits payments for pneumococcal vaccine and is administration if they are not reasonable and necessary for the prevention of illness. This extends to the pneumococcal vaccine provision the same safeguards which apply to all Medicare payments, that is, protection against unreasonable and unnecessary charges. This provision would, of course, give the Secretary authority to prevent the vaccine from being administered to individual recipients more frequently than necessary. According to a recent report by the Office of Technology Assessment, the vaccination is effective for at least three years; expert opinion indicates that the period of effectiveness may be considerably longer, perhaps providing lifetime coverage. The Committee expects the Secretary to assure that Medicare does not pay for vaccinations administered with more frequency than the minimum period of recognized effectiveness. The provision is not intended to give the Secretary the authority to limit the vaccine payment to only certain groups or categories of Medicare recipients. The Committee intends that Medicare payments for pneumococcal vaccine be available to all persons covered by the Medicare program.

MEDICARE PAYMENT LIABILITY SECONDARY WHERE PAYMENT CAN BE MADE UNDER AN AUTOMOBILE INSURANCE POLICY (SECTION 26)

Under the Committee's bill, medicare would have residual rather than primary liability for the payment of services required by a beneficiary as a result of an injury or illness sustained in an auto accident where payment for the provision of such services can also be made under an automobile insurance policy. Under this provision, it is expected that medicare would ordinarily pay for the beneficiary's care in the usual manner and then seek to be reimbursed by the private insurance carrier after, and to the extent that, such carrier's liability under the private policy for the services has been determined.

Under present law, medicare is the primary payor (except where a workmen's compensation program is determined to be responsible for payment for needed medical services) for hospital and medical services received by beneficiaries. This is true even in cases in which a beneficiary's need for services is related to an injury or illness sustained in an auto accident and the services could have been paid for by a private insurance carrier under the terms of an automobile insurance policy. As a result, medicare has served to relieve private insurers of obligations to pay the costs of medical care in cases where there would otherwise be liability under the private insurance contract. The Committee believes that the original concerns that prompted inclusion of this program policy in the law—the administrative difficulties involved in ascertaining private insurance liability and the attendant delays in payment—no longer justify retaining the policy, particularly if it is understood that immediate payment may be made by medicare with recovery attempts undertaken only subsequently when liability is established.

In order to avoid excessive administrative costs and efforts in pursuing minor recoveries, the Committee expects the Secretary to estab-

lish in regulations rules regarding the minimum amounts estimated as recoverable and the procedures for seeking recovery from private carriers. Such procedures would be similar to those currently employed by medicare in seeking recovery in workmen's compensation cases.

HOSPITAL TRANSFER REQUIREMENT FOR SKILLED NURSING FACILITY COVERAGE (SECTION 27)

The Committee bill contains a provision under which the 14-day period within which a medicare beneficiary must be transferred from a hospital to a skilled nursing facility under current law in order to qualify for post-hospital extended care benefits (in a skilled nursing facility) would be extended to 30 days. The 14-day limit on readmission to the skilled nursing care facility would also be extended to 30 days.

This provision incorporates without change into the Committee's bill an amendment recommended by the Committee on Ways and Means, which has jurisdiction over provisions affecting Part A of the Medicare program.

OUTPATIENT SURGERY (SECTION 28)

The bill would provide medicare reimbursement for the cost of ambulatory surgical centers when used to perform certain surgical procedures. In addition, the physician's reasonable charge for performing those same procedures on an outpatient basis would be reimbursed at 100 percent provided the physician performing the surgery agreed to accept assignment.

Under present law, medicare reimburses 80 percent of a physician's fee for surgery, regardless of the setting in which the surgery is performed—in a hospital, the outpatient department of a hospital, or an ambulatory surgical center. Medicare will also reimburse 100 percent of the facility's cost if the surgery is performed in a hospital and 80 percent of the facility's cost if the surgery is performed in a hospital outpatient department or in a free-standing ambulatory surgical center that is owned by the hospital. However, medicare law prohibits reimbursement for any costs incurred by a surgical facility if the facility is not hospital-affiliated.

There are a number of surgical procedures which are ordinarily performed on an inpatient basis but which can, consistent with sound medical practice, be performed on an outpatient basis for far less cost. Medicare, however, discourages the appropriate use of ambulatory surgery since the facility cost is fully reimbursed only on an inpatient basis and, in the case of all free-standing centers, is not reimbursed at all.

This provision would provide 100 percent reimbursement for services furnished by ambulatory surgical facilities for the performance of procedures which, although appropriately performed on a hospital inpatient basis, are determined by the Secretary to be also safely performed in an ambulatory surgical center. It is not the Committee's intent that this list include surgical procedures which would be

performed on an outpatient basis in the absence of the elaborate surgical facilities in an ambulatory surgical center. For example, it would not be appropriate to cover the types of surgical procedures routinely performed in a physician's office in the more costly setting of an ambulatory center. The Committee expects that the ambulatory center will serve as a setting to be used in lieu of hospital inpatient facilities. The reimbursement authorized under this provision would be paid only where the ambulatory surgical center agreed to accept the medicare payment as payment in full. The ambulatory surgical center would be required to meet certain health and safety standards.

The physician performing such procedures in a free-standing ambulatory surgical center or in the outpatient department of a hospital would be reimbursed 100 percent of the medicare reasonable charge for the services (including all pre- and post-operative services) furnished in connection with the procedure, provided the physician agrees to accept assignment.

In developing the list of procedures eligible for such reimbursement, the Secretary would be required to consult with the National Professional Standards Review Council and appropriate medical organizations, including specialty groups.

TECHNICAL AMENDMENT TO END-STAGE RENAL DISEASE PROGRAM (SECTION 29)

The bill amends the end-stage renal disease program to correct a defect in present law which has inadvertently resulted in certain reimbursement problems for nonprofit organizations assisting home dialysis patients. In addition, the bill changes the reporting date for the Secretary's annual reports to the Congress on the medicare renal disease program from April 1, to July 1, and provides that the determination of need for the facility made by the State Health Planning and Development Agency shall be conclusive.

Under present law, the Secretary may enter into agreements with providers and facilities to reimburse them for the full reasonable cost of the purchase and maintenance of dialysis equipment used by individuals who dialyze at home. However, certain nonprofit organizations which were engaged in assisting home dialysis patients to obtain and maintain such equipment at the time this provision was enacted in 1977, have been denied reimbursement under this provision.

Under the bill, therefore, the Secretary may enter into agreements with organizations such as State kidney programs and nonprofit institutions to provide machines to beneficiaries through direct purchase. The Committee expects that the Secretary will enter into such agreements with entities that demonstrate to his satisfaction that they can provide dialysis machines and supportive equipment economically and efficiently. Like providers and facilities, these entities would be reimbursed on the basis of their reasonable costs and would be required to provide the Secretary full access to cost and other data and submit reports as required by the Secretary with respect to cost, management and use of equipment. Should the Secretary find that such an entity fails to provide equipment efficiently and economically, the Committee expects that the Secretary would terminate the agreement.

The Committee's bill changes the reporting date for the annual renal disease program reports to allow the Secretary more time to gather and analyze the data required in such reports.

Finally, instances have come to the Committee's attention where despite a finding by the fully or conditionally designated State Health Planning and Development Agency that a new or expanded renal disease facility is needed, the Department has also proposed to make a determination on the issue of need. While no instances are known to have occurred where the decision differed, the Committee bill assures that questions of need will be decided by the State planning agency, as is appropriate in terms of its function, and will not be second guessed by the Department. The Department would, of course, still have authority to make determinations relating to appropriate reimbursement and so on.

PREADMISSION DIAGNOSTIC TESTING (SECTION 30)

Under the Committee's bill, diagnostic tests performed on an outpatient basis within 7 days of a patient's admission to the hospital would be reimbursed in full (with no deductibles or coinsurance).

In some cases, the diagnostic tests necessary prior to treatment as an inpatient can be performed on an outpatient rather than inpatient basis. Where this is possible, the patient's length of stay in the hospital can be reduced with substantial savings in hospital expenditures. However, whereas the diagnostic testing provided on an inpatient basis is reimbursed at 100 percent, the same service provided on an outpatient basis is reimbursed at the 80 percent rate. Thus, the patient has an economic incentive to be admitted as an inpatient for the testing.

The bill would eliminate any such incentive by providing for reimbursement at the 100 percent rate for outpatient diagnostic tests provided within seven days of admission to the same hospital where the outpatient tests are furnished. (Not only the hospital costs, but also the reasonable charges of physicians in the fields of radiology and pathology if the physicians accept assignment of the medicare claim would be reimbursed at the 100 percent rate, just as they would be on an inpatient basis.) Because of the administrative difficulty of coordinating claims for tests furnished in a hosptial other than the one where the beneficiary is subsequently admitted as an inpatient, the Secretary would be directed to provide for payment-in-full for diagnostic services provided in these settings only to the extent feasible. The Secretary, however, would be required to report to the Congress a year after enactment as to the progress in developing the policy necessary to implement this additional coverage.

STUDIES AND DEMONSTRATION PROJECTS (SECTION 31)

The bill would require the Secretary to study or conduct demonstrations and report to Congress with respect to the following issues:

Coverage for Orthopedic Shoes.—Under present law, orthopedic shoes and other supportive devices for the feet are generally excluded from medicare coverage. The only situation in which the exclusion

does not apply is if the orthopedic shoe is provided as an integral part of a leg brace. However, it would be costly to provide coverage for orthopedic shoes, even if the coverage were limited to cases where a physician certifies that the shoes are medically necessary. This provision would direct the Secretary to study and submit legislative recommendations to the Congress no later than January 1, 1981, with respect to the coverage of orthopedic shoes where such shoes are required as an appropriate part of medical treatment.

Expanded Coverage for Services of Clinical Social Workers.—Services furnished by clinical social workers are presently covered when furnished to inpatients of hospitals and skilled nursing facilities, as home health services for those who are otherwise eligible for home health benefits, and when furnished incident to a physician's service. Under the Committee's bill, psychiatric social workers' services would also be covered when furnished in a community mental health center. This provision would direct the Secretary to conduct a demonstration project and submit recommendations, no later than 24 months after enactment, for any legislative changes with respect to additional coverage for services of clinical social workers.

Nutritional Therapy for Renal Disease Patients.—The Secretary would be authorized the make further studies, conduct a demonstration project and submit legislative recommendations to the Congress, no later than 24 months after enactment, as to whether the use of nutritional therapy in early renal failure, utilizing (but not limited to controlled protein substances, can retard or arrest the progression of the disease with a resultant deferment of dialysis. Some recent studies reported in the professional literature have indicated that chronic renal failure may be retarded or even arrested by controlling dietary protein intake. The potential impact of such nutritional therapy on the treatment of chronic renal failure could be significant. Moreover, the cost of the present dialysis-oriented medicare renal disease program could be somewhat reduced if such a therapeutic approach were found to be viable in a substantial number of cases. The Committee expects that in establishing the demonstration project the Secretary will consult physicians with nutritional expertise who have had experience in treating patients with chronic renal disease.

Expanded Coverage for Respiratory Therapy Services.—Under present law, services furnished by respiratory therapists are covered when furnished as an inpatient service in a hospital or skilled nursing facility or as a service furnished by the outpatient department of a hospital. Under the provision, the Secretary would be directed to study the need for coverage of respiratory therapy services as a home health benefit and recommend. no later than 24 months after enactment, under what circumstances and conditions respiratory therapy services should be covered, for example, by type of medical diagnosis.

100 Percent Reimbursement for Second Opinions for Surgery.—The Committee believes that sufficient evidence exists that obtaining a second opinion can in many cases avoid unnecessary surgery to warrant consideration of providing 100 percent reimbursement for the second opinion. The 100 percent payment, in lieu of the usual 80 percent coverage of the physician's fee, would, it is hoped, encourage

more beneficiaries to seek second opinions. There is some concern, however, as to what effect such a higher rate of payment would have on overall program costs. There might also be administrative problems in determining when the 100 percent reimbursement is appropriate. Under the Committee's bill, the Secretary would, therefore, be required to evaluate demonstration projects currently being conducted by HEW on 100 percent reimbursement for surgical second opinions and report to the Congress, no later than 12 months after enactment, on the effect on surgical rates, the effect on program expenditures and any problems involved in administering such a program.

Home Health Services of Registered Dietitians.—In recent years nutritional counseling and management by registered dietitians, particularly for the aged, has been recognized as an important component of patient care. While medicare does recognize for reimbursement purposes the salary of a dietitian employed by a home health agency to provide general guidance on nutritional matters, no coverage is provided with respect to visits that might be made by the dietitian to the patient's home. To help evaluate alternative possibilities for changing current law, the Secretary would be directed to study (and, if necessary, conduct a demonstration project) on questions related to the coverage of dietitian visits, e.g., whether the number of covered visits should be related to diagnosis, and what criteria might be appropriately employed to assure proper utilization. The Secretary is to submit to the Congress a report on the study and any demonstration projects along with any legislative recommendations no later than 24 months after enactment.

Study of Costs of Various Types of Foot Care.—Under present law there are a number of foot conditions currently excluded as routine foot care that are both pathological and, in many cases, severely disabling rather than merely irritants or inconveniences. The Secretary is directed, therefore, to make a comprehensive analysis of the cost of expanded coverage of foot care, including the cost effects of alternative approaches to improving medicare coverage for specific types of foot conditions. The Secretary is to submit the analysis to the Congress within 24 months after enactment.

PROVIDER REIMBURSEMENT REVIEW BOARD (SECTION 32)

The bill authorizes the Provider Reimbursement Review Board to determine, on its own motion or at the request of a provider of services, whether it has jurisdiction over an issue brought before it by the provider. On the basis of a determination by the Board that it is without authority to decide the question (or if the Board fails to render such a determination within 30 days of the provider's request) the provider would be permitted to commence a civil action with respect to the matters in controversy without further administrative review.

Under present law, a provider's dissatisfaction with a particular determination made by its fiscal intermediary on the basis of a regulation issued by the Secretary must first be brought to the Board, even though the Board may not have the authority to reverse or overrule the regulation. (The Board has no authority, for example, to rule

on the legality of the Secretary's regulations but it must, nonetheless, conduct a full review of the challenge.) The effect of this process has been to delay the resolution of controversies for extended periods of time and to require providers to pursue a time-consuming and irrelevant administrative review merely to have the right to bring suit in a U.S. District Court. The committee's bill addresses this problem by giving medicare providers the right to obtain immediate judicial review in instances where the Board determines that it lacks jurisdiction to grant the relief sought.

ACCESS TO BOOKS AND RECORDS OF SUBCONTRACTORS (SECTION 33)

The bill provides that medicare will not reimburse amounts paid by providers under contracts for services between the provider and any of its subcontractors, whose value or cost over a twelve month period is $10,000 or more and which are entered into after enactment of the bill, unless such contracts contain a clause providing that the subcontractor shall make available to the Secretary and the Comptroller General, upon request, the contract, and the books, documents and records of the subcontractor that are necessary to verify the nature and extent of the costs incurred by the provider for a service covered by the specific subcontract. Books, papers and records covered by this provision of the bill must be preserved for three years after the furnishing of services pursuant to the contract.

Under present law, the Secretary does not have access to the books and records of medicare subcontractors unless the subcontractor is shown to be related to the provider. Unlike contracts for goods, contracts for services can pose difficult valuation problems. Consequently, without access to subcontractors' books, the detection and prevention of fraud and abuse can be difficult.

The committee believes that this provision of the bill is necessary both to strengthen the Secretary's capacity to effectively preclude or detect fraud and abuse and to conform medicare practice to the prevailing practice of other Federal agencies which buy services in the private sector. Moreover, the provision is moderate in scope since it includes only contracts that have a substantial service component (the intent of the value or cost standard is to permit the Secretary to assess the actual terms of the contract) and applies only to contracts entered into after enactment of the bill. In including this provision in the bill, it is not the Committee's intent to subject subcontractors to "fishing expeditions" or other unnecessarily burdensome or overly intrusive demands. The Committee expects the Secretary and the Comptroller General to avoid demanding books and records of a subcontractor unless there exists reason to believe that the cost or services of such contractor are in some way excessive or inappropriate, or the appropriateness of the costs cannot be judged without access to the specific books and records requested.

OTHER ISSUES

Blood Policy.—The Committee notes that during its consideration of this legislation it considered recommending revisions to the cur-

rent Medicare policy concerning retention of a separate deductible for blood, payment of the nonreplacement fee, and other reimbursement issues. The Committee concluded that it would not recommend changes at this time, but rather agreed to study these issues and related issues of national blood policy in further hearings.

Enteral Therapy.—The Committee is concerned that the Medicare program should provide coverage for enteral therapy, a special feeding procedure for persons who are unable to take nourishment through the normal process. Parenteral therapy, where nutrients are fed directly into the vein, is now covered. But coverage for enteral feeding, which may involve use of a shunt into the intestine, a tube into the stomach, or similar procedures, is sometimes denied for noninstitutionalized patients. The Committee believes HEW has sufficient authority under current law to provide coverage for enteral therapy, whether provided to institutionalized or noninstitutionalized persons, while instituting sufficient safeguards to assure that coverage for enteral therapy will not lead to payments for a whole range of special dietary arrangements, which could be both costly and unjustified in terms of program expenditures. The Committee is directing HEW to fully explore its current authorities in order to provide coverage of enteral therapy for patients who have a blockage which prohibits normal feeding.

III. Cost of Carrying Out the Bill

The estimated costs of carrying out the bill provided to the committee by the Director of the Congressional Budget Office follow:

U.S. Congress,
Congressional Budget Office,
Washington, D.C., March 17, 1980.

Hon. Harley O. Staggers,
Chairman, Committee on Interstate and Foreign Commerce,
U.S. House of Representatives,
Washington, D.C.

Dear Mr. Chairman: Pursuant to Section 403 of the Congressional Budget Act of 1974, the Congressional Budget Office has prepared the attached cost estimate for H.R. 3990, the Medicare Amendments of 1980.

Should the Committee so desire, we would be pleased to provide further details on the attached cost estimate.

Sincerely,

Alice M. Rivlin, *Director.*

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

March 17, 1980.

1. Bill No.: H.R. 3990.
2. Bill title: Medicare Amendments of 1980.
3. Bill status: As ordered reported by the Committee on Interstate and Foreign Commerce on March 4, 1980.
4. Bill purpose: The bill amends title XVIII of the Social Security Act with respect to the medicare program. The bill provides for a va-

riety of benefit improvements. Several provisions would reduce out-of-pocket expenses of beneficiaries by either increasing the total amount payable within a year for particular services or by reducing copayments. Other provisions would expand benefits by making certain classes of providers or certain services of some providers eligible for reimbursement. The bill contains several provisions that alter the conditions or requirements relating to enrollment or reenrollment in the medicare programs. Finally, the bill includes several provisions that would reduce program outlays either by encouraging more efficient provision of medical care services or by making changes in payment procedures and requirements.

5. Cost estimate:

[By fiscal years, in millions of dollars]

	1980	1981	1982	1983	1984	1985
A. DIRECT SPENDING PROVISIONS						
Medicare:						
Estimated budget authority	−1	−1	7	9	9	11
Estimated outlays:						
Sec. 2 Home health services	4	21	35	56	91	154
Sec. 3 Elimination of 2d waiting period for reentitled disability beneficiaries	4	25	44	63	68	75
Sec. 4 Report on coverage of medicare beneficiaries outside the United States	(1)	(1)	(1)	(1)	(1)	(1)
Sec. 5 Dentists' services	2	15	16	19	21	24
Sec. 6 Treatment of plantar warts	0	2	2	2	2	2
Sec. 7 Community mental health centers	0	20	75	90	110	140
Sec. 8 Comprehensive outpatient rehabilitation facility services	0	5	13	15	17	20
Sec. 9 Optometrists' services	0	2	2	2	3	3
Sec. 10 Antigens	(1)	(1)	(1)	(1)	(1)	(1)
Sec. 11 Payment where beneficiary not at fault	(1)	(1)	(1)	(1)	(1)	(1)
Sec. 17 Payment to providers of services	0	−6	−8	−10	−12	−15
Sec. 18 Limit on premium increases due to late enrollment	0	2	9	10	11	14
Sec. 19 Reenrollment and open enrollment in pt. B	(1)	(1)	(1)	(1)	(1)	(1)
Sec. 20 Chiropractors' services	7	44	49	55	61	68
Sec. 21 Increase in outpatient mental health benefits under pt. B	0	28	61	77	94	114
Sec. 22 Limitation on payments to radiologists and pathologists	0	−10	−17	−20	−26	−30
Sec. 24 Outpatient physical therapy services	0	2	4	5	5	5
Sec. 25 Medicare coverage of pneumococcal vaccine and its administration	0	49	35	39	21	23
Sec. 26 Medicare payment liability secondary in automobile accident cases	0	−8	−18	−42	−97	−112
Sec. 27 Hospital transfer requirement for skilled nursing facility coverage	(1)	(1)	(1)	(1)	(1)	(1)
Sec. 28 Outpatient Surgery	0	−1	−2	−4	−6	−9
Sec. 29 Technical renal disease amendments	(1)	(1)	(1)	(1)	(1)	(1)
Sec. 30 Preadmission diagnostic testing	0	−3	−6	−9	−12	−16
Sec. 31 Studies and demonstration projects	0	1	2	0	0	0
Total, medicare outlays	17	188	296	338	351	460
B. AMOUNTS SUBJECT TO APPROPRIATION ACTION						
Medicaid:						
Sec. 2 Home health services:						
Required budget authority	0	−2	−2	−3	−3	−4
Estimated outlays	0	−2	−2	−3	−3	−4
Total outlays	17	186	294	335	348	456

[1] Negligible costs or savings.

The costs of this bill fall within budget function 550.

Portions of the bill would reduce future federal liabilities through a change to an existing entitlement and therefore could permit subsequent appropriations action to reduce the budget authority for the medicaid program. The figures shown as "Required Budget Authori-

ty" represent that amount by which budget authority for the medicaid program could be reduced, as a result of this bill, below the level needed under current law.

6. Basis of estimate: This estimate assumes an enactment date of June 30, 1980. Most provisions therefore do not show any costs or savings for fiscal year 1980 because of either the lead time necessary for development and promulgation of regulations or the phasing-in of the provision by provider accounting years.

The estimates for Sections 5, 6, 7, 8, 9, 10, 11, 17, 18, 19, 20, 21, 22, 23, 24, 27, and 28 were provided by the Office of Financial and Actuarial Analysis of the Health Care Financing Administration. CBO prepared estimates for Sections 2, 3, 25, 26, 30, and 31. Discussion of the basis of estimate for these sections follows.

Section 2—Home Health

This section would generate new costs for the medicare program in four ways. It would remove the current limit on home health visits of one hundred per spell of illness under the Hospital Insurance Program (HI) and one hundred per calendar year under the Supplementary Medical Insurance Program (SMI). Beneficiaries who currently exhaust their visits would therefore be entitled to additional visits. The section would remove the three-day prior hospitalization requirement for HI home health services. Persons who have only HI coverage would be able to utilize home health services as if they had SMI coverage as well. The section would eliminate application of the $60 SMI deductible with respect to home health care services. This would directly reduce the cost of medicare home health care for some beneficiaries. Finally, the section would make occupational therapy a primary home health care service. Under current law occupational therapy services can be rendered only if they are incidental to those of one of the primary home health care services—skilled nursing, physical therapy, and speech therapy. Beneficiaries would now be able to utilize all home health services on the basis on an established primary need for occupational therapy. This would generate greater utilization of occupational therapy services and other services as well.

Data for calendar year 1977 show that about 15 thousand people reached the hundred visit limit under HI or SMI. CBO assumes that this figure grows at a ten percent annual rate and therefore will be 21 thousand in fiscal year 1981. It is further assumed that one-third of these people would use about 40 extra visits each per year at a cost of $32.50 per visit in fiscal year 1981.

About 1.1 million people covered by HI do not have SMI coverage. The number of beneficiaries using home health services under SMI about seven per thousand enrollees. It is therefore estimated that 7700 additional people would be utilizing home health services. Each is assumed to use 30 visits at a cost of $32.50 per visit in fiscal year 1981.

The combined first-year costs for the two groups would be $17 million in fiscal year 1981. Outyear costs are derived by inflating this figure by the rate of growth for medicare home health services projected by CBO. The cost for fiscal year 1980 are assumed to be about one-quarter of the fiscal year 1981 cost.

Many persons who currently are exhausting or not receiving medicare home health benefits are likely to be utilizing home health services under medicaid. CBO estimates that savings to the medicaid program would be generated by the transfer of about four thousand people back to medicare financing. Each person is assumed to incur 50 visits at a cost of $32.50 in fiscal year 1981, of which 27.5 percent would be incremental federal medicaid savings. Outyear savings are projected to grow at the same rate as the medicaid program.

The removal of the SMI deductible for home health care services is assumed to have no cost impact. The elimination of the three-day prior hospitalization requirement under HI has the effect of removing the distinction between HI and SMI home health care services. It is assumed that home health care would therefore become an HI service exclusively and that no deductible would apply.

Occupational therapy is a rapidly growing part of medicare home health services. In calendar year 1977 it represented 1.1 percent of all medicare home health care reimbursements, up from .4 percent in calendar year 1974. CBO assumes that reimbursement for occupational therapy services will continue to grow quickly and reach 4.5 percent in fiscal year 1985. Since occupational therapy services resemble those of physical therapy in many respects, it is assumed that its percentage of total home health care reimbursement would reach that of physical therapy, 10 percent, if it became a primary service. This percentage is assumed to be attained in fiscal year 1985, because the supply of registered occupational therapists and certified occupational therapy assistants would have to expand over time to meet the increased demand for occupational therapy. The cost impact in all years is derived from the increase in the percentage of total medicare home health care costs represented by occupational therapy. It is additionally assumed that every three occupational therapy visits will generate one visit by an allied profession. Each year's cost for occupational therapy services is therefore multiplied by 33 percent to derive the estimated total cost. Fiscal year 1980 costs are estimated to be one-quarter of fiscal year 1981 costs.

Section 3—Elimination of Second Waiting Period for Reentitled Disability Beneficiaries

This provision would eliminate the waiting period for reinstatement for medicare benefits for Disability Insurance (DI) beneficiaries who return to the rolls after a period off the rolls. About 40,000 workers are estimated to terminate DI benefits in 1980 (based on recent experience) for reasons other than completion of a trial work period (such as recovery). Of this group an estimated 5,000 persons are expected to return to the rolls within the year, thereby becoming eligible for resumption of medicare. The per enrollee cost in fiscal year 1980 for HI is estimated to be $850 and for SMI, $390. These costs are expected to increase at rates consistent with CBO's projected growth rates for the HI and SMI programs. Because of the assumed June 30, 1980 enactment date, the first year costs are reduced by three-quarters.

Section 25—Coverage of Pneumococcal Vaccine and Its Administration

This section would make pneumococcal vaccine and its administration a new benefit under SMI for which no coinsurance payment would

be required. CBO's estimate of the cost of this provision builds on that prepared by the Office of Technology Assessment (OTA) contained in the recently issued report entitled "A Review of Selected Federal Vaccine and Immunization Policies".

Conversations with OTA staff indicate that the cost of the vaccine should remain at $4.90 for the next couple of years. CBO assumes that this will be the price until fiscal year 1981, when it will rise to $5.25, followed by a further increase of $5.50 in fiscal year 1985. The labor cost is assumed to be that used by OTA in its analysis, $7.47 in calendar year 1978, inflated by CBO's projection of the CPI for medical care services. It is assumed that the vaccination will be sought primarily by aged SMI enrollees and that the number of disabled enrollees seeking it will be insignificant. An initial surge in vaccinations is expected, followed by a tapering off to a steady state rate. It is thus assumed that 15 percent of aged SMI enrollees will be vaccinated in fiscal year 1981, followed by 10 percent in fiscal years 1982 and 1983 and 5 percent thereafter.

No offsetting savings or costs resulting from the secondary effects of the vaccinations are assumed for the purposes of this estimate. CBO is currently conducting a separate study to determine what the magnitude of these costs and benefits be. These effects would include reduced medical and hospitalization costs resulting from a lowered pneumonia incidence and increased costs of treating future illnesses not prevented by vaccination among vaccines whose lives are prolonged as a result of the vaccination.

Section 26—Medicare Liability Where Payment Can be Made Under a Liability Insurance Policy

This section would provide for the recovery from automobile insurance policies of costs incurred by medicare for the treatment of injuries related to automobile accidents. Medicare hospital discharge data show that 10 percent of all HI discharges are for diagnoses involving accidents of all types. Similar data from the National Ambulatory Medical care Survey show that about 5 percent of all physician office visits by persons aged 65 or older are for accident-related conditions. It is assumed, therefore, that 10 percent of HI outlays and 5 percent of SMI outlays are for injuries resulting from accidents. Data from the Health Interview Survey show that about 10 percent of all accidents occurring in the 65 and older population are related to automobile accidents. Thus it is assumed that 10 percent of HI and SMI outlays for accident-related conditions are spent for treatment of injuries arising from automobile accidents. It is assumed for both HI and SMI that 95 percent of the accidents involving medicare beneficiaries occur where insurance coverage is present and that 50 percent of these have the potential for recovery of medical insurance payments. It is further assumed that the actual volume of recoveries will be 5 percent of the potential level in fiscal year 1981, 10 percent in fiscal year 1982, 20 percent in fiscal year 1983, and 40 percent in fiscal years 1984 and 1985.

Section 30—Preadmission Diagnostic Testing

This section would generate savings by encouraging the performance of diagnostic tests related to an inpatient stay on an outpatient

basis. CBO assumes, on the basis of examination of medicare data on hospital discharges by leading diagnosis, that the diagnostic tests associated with one-third of all medicare admissions could be performed on an outpatient basis. The number of admissions in fiscal year 1980 is estimated to be 10.4 million and is projected to grow at 5 percent a year. It is further assumed that a shift to preadmission diagnostic testing would occur in only a small percentage of the potentially eligible admissions—0.5 percent in fiscal year 1981 and 0.5 percent more in each succeeding fiscal year. For each admission where preadmission diagnostic testing is done, the savings are assumed to equal the medicare routine cost per day. This is estimated to be $132 in fiscal year 1980 and is projected to grow at rates consistent with CBO's latest projections of hospital cost per day for the medicare program.

Section 31—Studies and Demonstration Projections

This section requires the Secretary of the Department of Health and Human Services to carry out seven studies and demonstration project programs. CBO assumes that the cost of each new activity would range from $400 thousand to $500 thousand. The total cost is therefore assumed to be $3 million, which would be spread over fiscal years 1981 and 1982.

7. Estimate comparison: None.

8. Previous CBO estimate: On April 19, 1979, CBO provided the Committee on Ways and Means a cost estimate for H.R. 3236. That bill contained a provision identical to Section 3 of this bill. The estimate for that provision in H.R. 3236 and for Section 3 of this bill are identical, except for adjustments for a later assumed effective date in the first year.

9. Estimate prepared by: Eric Wedum.

10. Estimate approved by:

James L. Blum,
Assistant Director for Budget Analysis.

The Department of Health, Education and Welfare has submitted independent estimates of the cost of the bill to the Committee. They are similar but not identical to the CBO estimates. Those estimates follow:

HEW COST ESTIMATES FOR H.R. 3990—ASSUMING ENACTMENT JULY 1, 1980

[By fiscal years, in millions of dollars]

	1980	1981	1982	1983	1984	1985
OUTLAYS						
Sec. 2 Home health services (effective Jan. 1, 1981):						
Remove 100 visit limit	0	2	6	7	8	10
Remove 3-day prior hospitalization stay requirement	0	7	12	13	15	16
Remove HHA under SMI from $60 deductible requirement	0	(1)	(1)	(1)	(1)	(1)
Occupational therapy included as qualifying service	0	17	35	41	46	52
Remove licensure requirement for proprietary HHA's	0	(1)	(1)	(1)	(1)	(1)
Total	0	26	53	61	69	78
Sec. 3 Elimination of the 2d waiting period for disability	11	59	96	128	142	160
Sec. 4 Study of reciprocal agreements for coverage outside United States	(1)	(1)	(1)	(1)	(1)	(1)
Sec. 5 Dentists' services	2	15	16	19	21	24

See footnotes at end of table.

HEW COST ESTIMATES FOR H.R. 3990—ASSUMING ENACTMENT JULY 1, 1980

[By fiscal years, in millions of dollars]

	1980	1981	1982	1983	1984	1985
Sec. 6 Plantar warts	0	2	2	2	2	2
Sec. 7 Community mental health centers (effective Jan. 1, 1981)	0	20	75	90	110	140
Sec. 8 Comprehensive outpatient rehabilitation centers	0	5	13	15	17	20
Sec. 9 Optometrists' services	0	2	2	2	3	3
Sec. 10 Antigens	(1)	(1)	(1)	(1)	(1)	(1)
Sec. 11 Payment where beneficiary is not a fault	(1)	(1)	(1)	(1)	(1)	(1)
Sec. 12 Flexibility in application of standards for rural hospitals	0	0	0	0	0	0
Sec. 13 Certification and utilization review by podiatrists	0	0	0	0	0	0
Sec. 14 Physician treatment plan for speech pathology	0	0	0	0	0	0
Sec. 15 Payment for physicians' services when beneficiary has died	0	0	0	0	0	0
Sec. 16 Presumed coverage provisions	0	0	0	0	0	0
Sec. 17 Payment to providers of services	0	−6	−8	−10	−12	−15
Sec. 18 Limit on premium increases due to late enrollment	0	2	9	10	11	14
Sec. 19 Reenrollmet in pt. B:						
Unlimited enrollment	(1)	(1)	(1)	(1)	(1)	(1)
Open enrollment (includes 10 mo retroactivity)	1	16	22	25	29	32
Sec. 20 Chiropractors' services	7	44	49	55	61	68
Sec. 21 Outpatient mental health benefits (effective Jan. 1, 1981):						
Outpatient psychiatric	0	16	32	38	46	56
Outpatient psychological	0	12	29	39	48	58
Total	0	28	61	77	94	114
Sec. 22 Payments to radiologists and pathologists	0	−12	−17	−20	−26	−30
Sec. 23 Shortened pt. B termination period where medicaid ceased to pay	0	0	0	0	0	0
Sec. 24 Outpatient physical therapy	0	2	4	5	5	5
Sec. 25 Pneumococcal vaccine	0	55	30	30	30	30
Sec. 26 Medicare payment liability secondary in certain automobile insurance cases	0	0	−30	−35	−40	−45
Sec. 27 Hospital transfer requirement for SNF coverage	(1)	(1)	(1)	(1)	(1)	(1)
Sec. 28 Outpatient surgery	0	−1	−2	−4	−6	−9
Sec. 29 Technical renal disease amendment	(1)	(1)	(1)	(1)	(1)	(1)
Sec. 30 Preadmission diagnostic testing	(2)	(2)	(2)	(2)	(2)	(2)
Sec. 31 Studies and demonstration projects	(1)	(1)	(1)	(1)	(1)	(1)
Sec. 32 Provider reimbursement review board	0	0	0	0	0	0
Sec. 33 Access to books and records of subcontractors	0	0	0	0	0	0
Total outlays	[3] 21	[3] 257	[3] 375	[3] 450	[3] 510	[3] 591
BUDGET AUTHORITY						
Sec. 18 Limit on premium increases due to late enrollment	−1	−1	7	9	9	11

[1] Negligible cost or savings.
[2] Indeterminate.
[3] These cost estimates do not include additive effects of enacting sec. 18 and 19, including open enrollment. We do not have complete estimates, but we calculate additive costs at $3,000,000 in fiscal year 1980 and $8,000,000 in fiscal year 1981.

The Committee concurs with the estimates of the Congressional Budget Office.

IV. Other Matters To Be Discussed Under the House Rules

VOTE OF THE COMMITTEE

The bill, H.R. 3990, as amended, was ordered favorably reported by a voice vote.

OVERSIGHT FINDINGS

The Committee's principal oversight activities with respect to this program have been conducted by the Subcommittee on Health and the Environment in connection with its consideration of various legislative proposals. The findings are included as part of the explanation of the bill.

The Committee notes that additional oversight hearings have been conducted by the Subcommittee on Oversight and Investigations of this Committee and by the Ways and Means Committee.

No oversight findings or recommendations have been submitted to the Committee by the House Committee on Government Operations with respect to the subject matter contained in the bill.

V. Section-by-Section Analysis of the Bill

Section 1. The first section contains the short title of the bill "Medicare Amendments of 1979."

Section 2. Home Health Services

Section 2 of the bill amends the appropriate sections of title XVIII and title II of the Social Security Act and the Railroad Retirement Act of 1974 to eliminate the three-day prior hospitalization requirement under part A of Medicare; the present limitation on the number of visits available under parts A and B; and the part B $60 deductible with respect to home health services. These amendments are effective with respect to services furnished on or after July 1, 1980.

Sections 1814(a) and 1835(a) are amended by adding a new sentence at the end thereof to require that the physician who performs the certification for home health services and establishes the plan of treatment could not have a significant ownership interest in, or a significant financial or contractual relationship with, the home health agency providing the services. Sections 1814(a)(2)(D) and 1835(a)(2)(A) of the Social Security Act are amended to include occupational therapy as one of the skilled services that determines a beneficiary's eligibility for home health benefits. Section 1861(m)(4) of the Social Security Act is amended to provide that the home health aide services covered as a home health service must be furnished by a home health aide who has successfully completed a training program approved by the Secretary.

Section 1861(o) is amended to provide that proprietary home health agencies shall be subject to the same licensing requirements as nonprofit home health agencies and shall no longer be required to meet additional standards and requirements. Section 1861(o) is also amended by adding a new paragraph (7) to provide that a home agency, for the purpose of participation in the Medicare program, is one which meets such additional requirements (including conditions relating to bonding or establishing of escrow accounts for financial security purposes) as the Secretary finds necessary for the effective and efficient operation of the program. Section 1861(e) is amended by adding a new paragraph (4) which directs the Secretary to designate regional agencies or organizations to serve as intermediaries for home health agencies in that region except that a hospital-based home health agency would be assigned to such a designated regional intermediary only if the Secretary determines that this assignment results in the more effective and efficient administration of the Medicare program.

Section 1861(v)(1) is amended by adding a new subparagraph (G), which excludes cost related to bonding or establishing an escrow account and interest on borrowing incurred to repay Medicare overpayments (unless the agency was acting in good faith in borrowing the amounts) from the determination of reasonable cost for home health agencies. New subparagraph (G) also contains provisions relating to reimbursement of costs incurred by a home health agency under a

service contract. For service contracts entered into after the date of enactment of the bill, new subparagraph (G) prohibits reimbursement for amounts paid under home health agency contracts whose terms exceed 5 years or which determine the amount payable on the basis of a percentage of the home health agency's Medicare reimbursement. For existing percentage contracts, new subparagraph (G) limits reimbursement to the reasonable value of the services provided as determined by the Secretary.

The amendments relating to physician certification and training for home health aides are effective with respect to services furnished on or after July 1, 1980. The amendments directing the Secretary to designate regional intermediaries, eliminating the present additional requirements for proprietary home health agencies and providing authority for additional standards for home health agencies are effective immediately, except that the Secretary is directed to take administrative actions to assure that improvements, in accordance with the authority to establish additional standards, will be made with respect to home health services by June 30, 1980.

Section 3. Elimination of Second Waiting Period for Reentitled Disability Beneficiaries

Section 3(a) amends sections 226(b), 1811, and 1837(a)(1) of the Social Security Act, and section 7(d)(2)(ii) of the Railroad Retirement Act of 1974 by striking out the word "consecutive" wherever it appears, thereby modifying the medicare 24-month waiting period requirement so that these months need not be consecutive.

Section 3(b) further amends section 226 by adding a new subsection, which provides that, for an individual who is reentitled to the same type of monthly disability benefits, the 24-month waiting period may not include any month in a previous period of disability, if (1) the individual is reentitled as a disabled worker and the previous period of disability terminated more than 60 months before reentitlement; or (2) the individual is reentitled as an adult disabled since childhood, or as a disabled widow or widower, and the previous period of disability terminated more than 84 months before reentitlement.

Section 3(c) provides that these amendments apply to medicare protection for months after the month of enactment.

Section 4. Report on Coverage of Medicare Beneficiaries Outside the United States

Section 4(a) requires the Secretary of HEW to study the number of persons entitled to Medicare benefits who are unable to receive them because they are outside the United States and the approximate amount of payments involved. The study shall also include a review of alternative means of providing benefits to these persons, including the use of reciprocal agreements with other countries.

Section 4(b) requires the Secretary to report to Congress, together with his recommendations, within one year of enactment of the bill.

Section 5. Dentists' Services

Section 5(a) of the bill amends the present definition of physician in section 1861(r)(2) of the Social Security Act to provide that services performed by a doctor of dental surgery or of dental medicine are

covered where such services are covered when performed by a physician as defined in section 1861(r)(1) provided the doctor of dental surgery or of dental medicine is legally authorized to practice dentistry by the State in which he performs such functions and he is acting within the scope of his license.

Section 5(b) amends section 1814(a)(2)(E) of the Social Security Act to provide coverage for inpatient hospital services for the performance of a noncovered dental service where a physician (including a physician as defined in 1861(r)(2)) certifies that not only a patient's underlying medical condition and clinical status but also the severity of the dental procedure itself warrants hospitalization.

Section 5(c) amends section 1862(a)(12) of the Social Security Act by providing that hospital services for the performance of a noncovered dental procedure are not excluded services where the severity of the dental procedure warrants hospitalization.

Section 6. Treatment of Plantar Warts

Section 6 of the bill amends section 1862(a)(13)(C) of the Social Security Act to eliminate warts from the definition of the routine foot care that is excluded as a covered service.

Section 7. Community Mental Health Centers

Section 7(a) amends section 1832(a)(2) of the Social Security Act to include community mental health center services within the scope of benefits under Part B of Medicare.

Section 7(b) amends section 1832(a)(2)(B)(i) to include physician's services furnished to a patient in a community mental health center or a comprehensive outpatient rehabilitation facility within the scope of benefits under Part B of Medicare.

Section 7(c) amends section 1833(c) to exclude mental health services furnished to patients of a community mental health center from the annual limitation on payment for outpatient metal health services.

Section 7(d) amends title XVIII of the Social Security Act by adding a new section 1834, entitled, "Limitation on Community Mental Health Center Services." New section 1834 limits payment for community mental health center services furnished to a beneficiary to 15 outpatient visits and 60 partial hospitalization visits during any calendar year.

Section 7(e) amends section 1835(a)(2) of the Social Security Act by adding a new subpargraph (E), which requires a physician to certify (and recertify), in the case of community mental health center services, that (1) such services were required in connection with the treatment of mental, psychoneurotic, or personality disorder; (2) a plan for furnishing such services has been established by a physician or other qualified mental health professional (as defined for this purpose in new section 1861(bb)(3)) and is periodically reviewed and approved by a physician; (3) such services were furnished while the individual was under the case management of a physician; and (4) in the case of services provided with respect to a partial hospitalization visit the individual would otherwise require inpatient psychiatric services.

Section 7(f) amends section 1861(1) of the Social Security Act to extend Medicare provisions relating to agreements for the transfer of patients between skilled nursing facilities and hospitals to such agreements between community mental health centers and hospitals.

Section 7(g) amends section 1861(u) to include community mental health center in the definition of provider of services.

Section 7(h) makes a conforming amendment to section 1861(w)(1), which defines the term "arrangements" for Medicare purpose.

Section 7(i) amends section 1861 of the Social Security Act by adding a new subsection (bb) entitled, "Community Mental Health Center Services."

Paragraph (1) of new subsection (bb) defines the term "community mental health center services" to mean the following items and services furnished to an individual as an outpatient by a community mental health center or (to the extent permitted in regulations) by others under arrangements with them made by the center—

(A) Diagnostic, therapeutic, or rehabilitative services furnished at the facility and crisis intervention outside the facility, when furnished by a physician or a qualified mental health professional as defined in new section 1861(bb)(3).

(B) Drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered; and

(C) Such items and supplies as are ordinarily furnished to outpatients by community mental health centers in connection with an active mental health program of diagnosis and treatment; excluding, however, any item or service if it would not be covered if furnished to an inpatient of a hospital.

Paragraph (2) of new subsection (bb) defines the term "community mental health center" to mean a facility which—

(A) meets the definition of a community mental health center under section 201 of the Community Mental Health Center Act and the regulations prescribed under such Act;

(B) has a requirement that all mental health services are provided under the supervision of a physician or other qualified mental health professional;

(C) meets such requirements as the Secretary may prescribe with respect to staffing requirements and qualifications of the staff;

(D) maintains clinical records on all patients;

(E) has in effect a utilization review plan in accordance with regulations prescribed by the Secretary;

(F) has in effect an agreement with a hospital under section 1861(l) for the transfer of patients;

(G) in the case of a community mental health center in any State in which State or applicable local law provides for the licensing of community mental health menters, is licensed pursuant to such law;

(H) has appropriate procedures or arrangements (in compliance with applicable State and Federal law) for storing, administering, and dispensing drugs and biologicals; and

(I) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such center.

Paragraph (3) of new subsection (bb) defines the term "qualified mental health professional" to mean a clinical psychologist, psychiatric nurse or psychiatric social worker who has such qualifications as the Secretary shall establish by regulation.

Section 7(j) amends section 1864(a) of the Social Security Act to provide for the use of State agencies to determine compliance by community mental health centers with applicable provider conditions of participation.

Section 7(k) provides that the amendments made by section 7 become effective with respect to a community mental health center's first accounting period which begins on or after March 1, 1980.

Section (1) requires the Secretary to submit a report to the Congress recommending a definition of an outpatient mental health center which could be used to broaden the definition of community mental health center as established by the amendments made by section 7.

Section 8. Comprehensive Outpatient Rehabilitation Services

Section 8(a) of the bill amends section 1832(a)(2) of the Social Security Act to include comprehensive outpatient rehabilitation services among the medical and other health services for which payment may be made under medicare part B on behalf of an entitled beneficiary.

Section 8(b) adds to section 1835(a)(2) of the Social Security Act a new subparagraph (F) requiring as a condition of payment for comprehensive outpatient rehabilitation services that a physician certify that the services were required because the individual needed skilled rehabilitation services. a plan for furnishing such services has been established and is periodically reviewed by a physician, and the services were furnished while the individual was under the care of a physician.

Section 8(c) amends section 1861(u) of the Social Security Act to include comprehensive outpatient rehabilitation facilities within medicare's definition of a provider of services.

Section 8(d) amends section 1861(z) of such Act to require a comprehensive outpatient rehabilitation facility to have an overall plan and budget as described therein.

Section 8(e) adds to section 1861 of the Social Security Act a new section (cc) relating to comprehensive outpatient rehabilitation services and facilities.

Paragraph (1) of new subsection (cc) defines the term "comprehensive outpatient rehabilitation services" as including the following items and services furnished by a physician or other qualified professional personnel (as defined in regulations) to an outpatient of the facility under a plan established and periodically reviewed by a physician: physicians' services; physical therapy, occupational therapy, speech pathology services, and respiratory therapy; prosthetic and orthotic devices including testing, fitting, and training in their use; social and psychological services; nursing care by or under the supervision of a registered professional nurse; drugs and biologicals which cannot be self-administered; supplies, appliances and equipment; and such other medically necessary items and services for rehabilitation of the patient as are ordinarily furnished by such facilities. However, items and services would be excluded if they would not be covered when furnished to a hospital outpatient.

Paragraph (2) of the new subsection (cc) defines the term "comprehensive outpatient rehabilitation facility" as an institution which: is primarily engaged in providing (by or under the supervision of physicians) diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons; provides at least physicians' services (by physicians who are available at the facility on a full- or part-time basis), physical therapy, and social or psychological services; maintains clinical records on all patients; has policies established by a professional group including one or more physicians and provides for them to be carried out by a full- or part-time physician associated with the facility; requires that every patient be under the care of a physician; is licensed or meets State or local licensing requirements; has in effect a utilization review plan; has in effect an overall plan and budget that meets the requirements of section 1861(z); and meets such other health and safety conditions as the Secretary may find necessary, including conditions concerning qualifications of personnel.

Section 8(f) amends section 1863 of the Social Security Act to require that, as in the case of other providers, the Secretary of HEW shall, in developing health and safety conditions for comprehensive outpatient rehabilitation facilities, consult with specified governmental and private organizations, and to provide that such conditions may be varied for different areas or different classes of facilities and may, at the request of a State, be higher for such State than for other States.

Section 8(g) amends section 1864(a) of the Social Security Act to make provision for the use of State agencies to determine compliance with the conditions of participation for comprehensive outpatient rehabilitation facilities.

Section 8(h) provides that the amendments made by section 8 of the bill shall become effective with respect to a comprehensive outpatient rehabilitation facility's first accounting period which begins on or after March 1, 1980.

Section 9. Optometists' Services

Section 9(a) of the bill amends the definition of physician in 1861 (r)(4) of the Social Security Act to provide coverage of services furnished by optometrists related to the condition of aphakia.

Section 9(b) directs the Secretary to submit to the Congress by June 1, 1980, legislative recommendations with respect to medicare reimbursement for services furnished by optometrists in connection with cataracts and such other services as they are legally authorized to perform.

Section 10. Antigens

Section 10 of the bill amends section 1861(s)(2) of the Social Security Act by adding a new subparagraph (G) to provide coverage for antigens prepared by a physician, for a particular patient, including antigens which are forwarded to another qualified person (including a rural health clinic) for administration to such patient from time to time, by or under the supervision of another physician.

Section 11. Payment Where Beneficiary Not at Fault

Section 11 of the bill amends section 1879 of the Social Security Act by adding at the end thereof a new subsection (e). New subsection

(e) provides that where payment for inpatient hospital services or extended care services may not be made under part A of title XVIII of the Social Security Act on behalf of an individual entitled to benefits under such part solely because of an unintentional, inadvertent, or erroneous action with respect to the transfer of such individual from a hospital or skilled nursing facility that meets the requirements of sections 1861(e) or (j) of the Social Security Act by such provider of services acting in good faith in accordance with the advice of a utilization review committee, professional standards review organization, or fiscal intermediary, or on the basis of a clearly erroneous administrative decision by a provider of services, the Secretary may take such action with respect to the payment of such benefits as he determines may be necessary to correct the effects of such unintentional, inadvertant, or erroneous action.

Section 12. Flexibility in Application of Standards to Rural Hospitals

Section 12 of the bill amends section 1861(e) of the Social Security Act (which defines a hospital for medicare purposes) by adding a new sentence at the end thereof, which sentence provides that the term "hospital" also includes a facility of fifty beds or less which is located in an area determined by the Secretary to meet the definition relating to a rural area specified in subparagraph (A) of paragraph (5) of this subsection and which meets the other requirements of this subsection, except that—(A) with respect to the requirements for nursing services applicable after December 31, 1978, the Secretary may temporarily waive the requirements for such period as he deems appropriate where (i) there is a temporary shortage of qualified nursing personnel in the area, (ii) a registered nurse is rendering or supervising the nursing service provided during at least the regular daytime shift, and (iii) the Secretary determines that the employment of such nursing personnel as are available to the facility during the temporary period will not adversely affect patient health and safety; (B) with respect to health and safety requirements promulgated under paragraph (9) of this subsection, such requirements are to be applied in such manner as to assure that personnel requirements take into account the availability of technical personnel in the area and the scope of services rendered by the facility, and the Secretary is to provide for the continued participation of such a rural facility where the personnel requirements are not fully met, for such period as he determines that the facility is making good faith efforts to fully comply with the personnel requirements and the employment of such personnel as are available to the facility will not adversely affect patient health and safety; and (C) with respect to fire and safety requirements promulgated under paragraph (9) of this subsection, the Secretary may (i) waive (for such period as he deems appropriate) specific provisions of such requirements which if rigidly applied would result in unreasonable hardship for the facility and which, if not applied, would not jeopardize the health and safety of patients, and (ii) may accept a facility's compliance with all applicable State codes relating to fire and safety in lieu of compliance with the fire and safety requirements promulgated under paragraph (9) if he determines that such State has in effect fire and safety codes, imposed by State law, which adequately protect patients.

Section 13. Certification and Utilization Review by Podiatrists

Section 13(a) of the bill amends section 1861(r) of the Social Security Act (which defines the term "physician" for purposes of medicare) by modifying the definition in paragraph (3), relating to podiatrists. For purposes of medicare coverage, a doctor of podiatric medicine is a physician with respect to functions he is legally authorized to perform as such by the State in which he performs them. In addition, a doctor of podiatric medicine is defined as a physician for purposes of sections 1814(a) and 1835 of the Social Security Act (relating to physician certifications) and subsections (k) (relating to utilization review) and (m) (relating to the requirement that a home health patient be under the care of a physician) of section 1861; for such purposes, the definition extends only to functions that are consistent with the scope of podiatric practice in the State where the doctors of podiatric medicine performs them and that are consistent with the policies of any health care institution involved.

Section 13(b) amends section 1861(k)(2)(A) of the Social Security Act to provide that, although a doctor of podiatric medicine may serve as a physician member of a hospital or skilled nursing facility utilization review committee, such a committee must also have two physician members who are either doctors of medicine or doctors of osteopathy.

Section 14. Physician Treatment Plan for Speech Pathology

Section 14 of the bill amends section 1835(a)(2)(D)(ii) of the Social Security Act to allow a physician or the speech pathologist providing the speech pathology services to establish the plan of treatment required by this section.

Section 15. Payment for Physicians' Services Where Beneficiary Has Died

Section 15 of the bill amends section 1870(f) of the Social Security Act to provide for reimbursement for physicians' services where the beneficiary has died, on the basis of an unpaid bill, to an individual who has assumed the legal obligation to pay for the physicians' services. Alternative procedures for payment contained in 1870(f) are retained under this amendment.

Section 16. Presumed Coverage Provisions

Section 16 of the bill repeals section 1814(h) and (i) of the Social Security Act pertaining to presumed coverage for certain care provided in skilled nursing facilities and certain care provided by home health agencies and redesignates the remaining subsection accordingly.

Section 17. Payment to Providers of Services

Section 17(a) of the bill amends section 1814(b) of the Social Security Act to provide that (except for reimbursement for certain services to renal disease patients) Medicare reimbursement under Part A to providers of services will (subject to deductible and coinsurance provisions) be on the basis of reasonable cost as determined under section 1861(v) of the Social Security Act. Subsection (a) of the bill repeals the provisions of existing law under which payment to a provider is

limited to the provider's customary charges if these charges are lower than reasonable costs.

Section 17(b) amends sections 1833(a) of the Social Security Act (relating to reimbursement under part B) by striking out paragraphs (2) and (3) and inserting new paragraphs (2), (3), (4), and (5).

New paragraph (2) provides (subject to any unsatisfied deductible amounts) for reimbursement to providers of services based on the reasonable costs of covered services (as determined under section 1861 (v) of the Social Security Act) less any coinsurance amounts the provider is authorized to charge beneficiaries (as described in clause (ii) of section 1866(a)(2)(A)) but in no case may the amount reimbursed exceed 80 percent of the reasonable cost of the services. This provision does not apply to rural health clinic services, community mental health center services, comprehensive outpatient rehabilitation services, facility services furnished in connection with certain ambulatory surgical procedures (added by section 28 of the bill), and certain preadmission diagnostic services described in new paragraph (5).

The new paragraph (2) also restates, without substantive change, the existing rule for reimbursement to independently practicing physical therapists.

In similar fashion, new paragraph (3) provides, with respect to rural health clinic, community mental health center, and comprehensive outpatient rehabilitation services, for coinsurance amounts to be offset against costs; except that in the case of such clinics, centers, and facilities, the costs involved are amounts which are reasonable and related to the cost of furnishing covered services or based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under Section 1861(v)(1)(A) of the Social Security Act.

New paragraph (4) provides for reimbursement of facility services furnished in connection with certain ambulatory surgical procedures at an amount established by the Secretary for the procedure under new sections 1833(i)(2)(A) and 1833(i)(2)(B) which are added by sections 28 of the bill.

New paragraph (5) provides for reimbursement of the reasonable cost of preadmission diagnostic services furnished by the outpatient department of a hospital within 7 days of the beneficiary's admission as a hospital inpatient.

Section 17(c) of the bill provides that the amendments made by this section shall be effective with respect to services provided on or after January 1, 1980.

Section 18. Limit on Premium Increases Due to Late Enrollment

Section 18 of the bill amends section 1839(d) of the Social Security Act by limiting the premium increase for late enrollment provided for in the subsection to 30 percent.

Section 19. Reenrollment and Open Enrollment in Part B

Section 19(a) repeals section 1837(b) of the Social Security Act which limits reenrollment in Part B of Medicare.

Section 19(b) amends Sections 1837(e) and 1837(g)(3) of the Social Security Act to provide for a general open enrollment period under Part B of Medicare.

Section 19(c) amends Section 1838(a)(2)(E) to provide that the coverage period for persons enrolling after their initial enrollment period shall begin the first day of the third month following the month they enroll.

Section 20. Chiropractors Services

Section 20(a) of the bill amends section 1861(r)(5) of the Social Security Act to provide coverage for services furnished by chiropractors for manipulation of the spine where the existence of subluxation of the spine can be demonstrated by an X-ray or other chiropractic clinical findings.

Section 20(b) amends section 1861(s)(3) by adding a new subparagraph (B) that includes diagnostic X-ray tests which are furnished by a chiropractor and which are reasonable and necessary in the diagnosis of a subluxation of the spine in the definition of covered medical and other health services.

Section 21. Increase in Outpatient Mental Health Benefits Under Part B

Section 21(a)(1) of the bill amends section 1833(c) of the Social Security Act to increase the limit on Part B payments for the treatment of mental, psychoneurotic, or personality disorders of individuals who are not hospital inpatients to 80 percent of reasonable charges, not to exceed $750 (80 percent of $937.50) in any calendar year.

Section 21(a)(2) makes a conforming amendment to section 1866(a)(2)(A), relating to agreements with providers of services.

Section 21(a)(3) provides that these amendments apply to expenses incurred in calendar years beginning after the date of enactment.

Section 21(b)(1) amends section 1861(r) (which defines the term "physician" for purposes of Medicare) by adding a new clause (b), which provides for coverage of services furnished to an individual who is not a hospital inpatient by a clinical psychologist who is licensed by the State (or otherwise legally authorized to perform clinical pyschologist's services) and who meets uniform minimum requirements prescribed by the Secretary if the following conditions are met: (1) the individual is referred to the psychologist by a pyhsician; (2) the individual is receiving such services in connection with the treatment of mental, psychoneurotic, or personality disorders; and (3) the services are those which the clinical psychologist is legally authorized to perform.

Section 21(b)(2) amends section 1835(a)(2)(B), (relating to physician certification and recertification) by adding a new clause which requires, in the case of covered services furnished to an outpatient by a clinical psychologist, the clinical psychologist to certify and recertify that the services are required for the treatment of mental, psychoneurotic, or personality disorders.

Section 22. Limitation on Payments to Radiologists and Pathologists

Section 22(a) amends subsections (a)(1)(B) and (b)(2) of section 1833 of the Social Security Act (relating to payment of Part B benefits) to limit reimbursement for inpatient radiological and pathological services at 100 percent of reasonable charges (with no deductible) to

those radiologists and pathologists who agree to accept assignment for all services furnished to hospital in patients enrolled under Part B.

Section 22(b) provides that the amendments made by section 22(a) apply to services furnished after the sixth calendar month beginning after enactment.

Section 23. Shortened Part B Termination Period for Certain Individuals Whole Premiums Medicaid Has Ceased to Pay

Section 23(a) amends section 1843(e) of the Social Security Act by adding a new sentence that requires the Part B coverage period of an individual who (in the last month of his coverage under a state buy-in agreement or in any of the following 6 months) files notice that he no longer wishes to participate in the Part B program, to terminate at the end of the month in which the notice is filed.

Section 23(b) specifies a technical conforming amednment to section 1838(b).

Section 23(c) specifies a technical conforming amendment to section 1843(g)(2).

Section 23(d) provides that the amendments made by section 23 apply to notices filed after the third calendar month after enactment.

Section 23(e) requires the coverage period under Part B of an individual whose coverage under a State buy-in-agreement is terminated and who has filed notice before the end of the third calendar month beginning after the date of the enactment of the bill that he no longer wishes to participate in the Part B program to terminate on the earlier of (1) the day specified in section 1838 without the amendments made by section 23, or (2) (unless the individual files notice before the day specified in this clause that he wishes his coverage period to terminate as provided in clause (1)) the day on which his coverage period would terminate if the individual filed notice in the fourth calendar month beginning after the date of enactment.

Section 24. Outpatient Physical Therapy Services

Section 24(a) amends section 1833(g) of the Social Security Act, as added by section 251(a)(2) of Public Law 92–603, to increase the limit on expenses incurred in any calendar year for certain outpatient physical therapy services provided by independently practicing physical therapists from $1,000 to $500.

Section 24(b) redesignates section 1833(g), as added by section 279(b) of Public Law 92–603, as section 1833(h).

Section 25. Medicare Coverage of Pneumococcal Vaccine and Its Administration

Section 25(a) amends Section 1861(s) of the Social Security Act to add "pneumococcal vaccine and its administration" to the list of covered Medicare Part B services and makes technical and conforming changes to Sections 1864(a) and 1862(a) of the Act.

Section 25(b)(1) amends Section 1833(a) of the Social Security Act to provide for Medicare payment of 100 percent of reasonable charges for pneumococcal vaccine and its administration. Section 25(b)(2) amends Section 1833(b) of the Act to provide for payment for such services without regard to the deductible. Section 25(b)(3)

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amends Section 1861(aa)(1) of the Act to include such services within the definition of rural health clinic services.

Section 25(c) provides that the amendments made by Section 25 shall apply to services furnished on or after July 1, 1980.

Section 26. Medicare Payment Liability Secondary in Certain Automobile Insurance Cases

Section 26 amends section 1862(b) of the Social Security Act (relating to exclusions from coverage) to: (1) prohibit Medicare payment for items or services to the extent that payment has been made or can reasonably be expected to be made under an automobile insurance policy; and (2) provide that Medicare payment for such items or services must be conditioned on reimbursement to the appropriate Medicare trust fund when notice is received that payment has been made under an automobile insurance policy.

Section 27. Hospital Transfer Requirement for Skilled Nursing Facility Coverage

Section 27 amends section 1861(i) to: (1) increase the period within which a beneficiary must be transfererd from a hospital to a skilled nursing facility in order to qualify for post-hospital extended care benefits from 14 days (28 days if there is a shortage of appropriate bed space in the area) to 30 days after the discharge from the hospital; and (2) increase the period following discharge from a skilled nursing facility within which the beneficiary can be readmitted to a skilled nursing facility without again meeting the 3-day prior hospitalizaton requirement from 14 days to 30 days.

Section 28. Outpatient Surgery

Section 28(a) amends section 1832(a) by adding a new subparagraph (G) that covers under Part B facility services furnished in connection with certain surgical procedures specified by the Secretary and performed in an ambulatory surgical center which meets health, safety, and other standards specified in regulations.

Section 28(b) adds to section 1833 of the Social Security Act a new subsection (i), relating to surgical procedures performed on an ambulatory basis.

Paragraph (1) of new subsection (i) requires the Secretary, in consultation with the National Professional Standards Review Council and appropriate medical organizations, to specify surgical procedures which are appropriately (when considered in terms of proper utilization of hospital inpatient facilities) performed on an inpatient basis in a hospital, but which also can be performed safely on an ambulatory basis in an ambulatory surgical center or a hospital outpatient department.

Paragraph (2)(A) of new subsection (i) requires payment for facility services furnished in connection with a specified surgical procedure performed in an ambulatory surgical center or hospital outpatient department to be equal to an amount that takes into account the costs incurred by such centers (or classes of centers) generally in providing the services and assures that the performance of the service in such an ambulatory surgical center or hospital outpatient depart-

ment will result in substantially ess amounts paid under Medicare than would have been paid if the services had been furnished on an inpatient basis.

Paragraph (2)(B) of new subsection (i) further provides for appropriate adjustments to the payment rate.

Paragraph (2)(B) of new subsection (i) requires the amount of payment for physician's services and services incident to a physician's services (including all pre- and post-operative services) furnished in connection with the specified surgical procedures to be the reasonable charge for such services if the physician accepts assignment.

Section 28(c) amends section 1835(a)(2) by adding a new subparagraph (G), which requires a physician to certify (and recertify) that services furnished in connection with a specified surgical procedure in an ambulatory surgical center are or were medically required.

Section 28(d) amends section 1861(u) to include ambulatory surgical center in the definition of provider of services.

Section 29. Technical Renal Disease Amendment

Section 29(a) amends Section 1881(c)(4) of the Social Security Act to provide that the Secretary may not refuse to certify the addition or expansion of a renal facility within a renal disease network area if such addition or expansion has received a certificate-of-need under Section 1523(a)(4)(B) of the Public Health Service Act.

Section 29(b) amends section 1881(e) of the Social Security Act to specify that the Secretary may enter into agreements with nonprofit entities for reimbursement of reasonable cost (without regard to deductibles and coinsurance) of dialysis equipment economically and efficiently furnished to beneficiaries who dialyze at home.

Section 29(c) amends section 1881(g) of the Social Security Act to change the date on which the Secretary is required to submit to the Congress a report on the end stage renal disease program from April 1 to July 1 of each year.

Section 30. Preadmission Diagnostic Testing

Section 30(a) amends section 1833(a)(1) of the Social Security Act by adding a new subparagraph (F) relating to preadmission diagnostic radiological or pathological services for which payment may be made under Part B and which are furnished to an individual by the outpatient department of a hospital within 7 days of the individual's admission to the same hospital as an inpatient or (to the extent practicable as determined by regulations), to another hospital by a physician in the field of radiology or pathology. New subparagraph (F) requires payment of the reasonable charges for such services if the physician agrees to accept an assignment for all physicians' services furnished by him to Medicare beneficiaries.

Section 30(b) requires the Secretary to report to Congress no later than one year after the date of enactment of the bill describing the policy which has been developed and implemented with respect to the amendments made by section 30(a) and section 17(b) of the bill as they concern payment for preadmission diagnostic testing furnished to an individual at a hospital within 7 days of an individual's admission to another hospital.

Section 31. Studies and Demonstration Projects

Section 31(a) requires the Secretary to develop and carry out a demonstration project to determine (1) the extent to which the commencement of nutritional therapy in early renal failure, utilizing (but not limited to) controlled protein substances, can retard or arrest the progression of the disease with a resultant substantive deferment of dialysis, and (2) the administrative, financial, and other aspects of making such nutritional therapy generally available as part of the benefits received under title XVIII of the Social Security Act.

Section 31(b) requires the Secretary to submit to the Congress, within one year after the date of enactment, a report (including any legislative recommendations) on the demonstration projects being conducted on the waiver of the applicable cost-sharing amounts which Medicare beneficiaries have to pay for obtaining a second opinion on having surgery performed.

Section 31(c) requires the Secretary to conduct a study of the circumstances and conditions under which services furnished by registered dietitians should be covered as a home health benefit under title XVIII of the Social Security Act.

Section 31(d) requires the Secretary to develop and carry out demonstration projects to determine the administrative, financial, and other aspects of making the services of clinical social workers more generally available as part of the benefits received under title XVIII of the Social Security Act.

Section 31(e) requires the Secretary to conduct, in consultation with appropriate professional organizations, a comprehensive study of methods for providing coverage under Part B of title XVII of the Social Security Act for orthopedic shoes for individuals with disabling conditions who require special fitting considerations or who require special shoes in conjunction with the use of an orthosis or foot support. The Secretary is directed to submit to Congress, no later than January 1, 1981, a report on the findings of this study and such specific legislative recommendations as appropriate with respect to the utilization, cost control, quality of care, and equitable and efficient administration of such an extension of coverage.

Section 31(f) requires the Secretary to conduct a study of the circumstances and conditions under which services furnished with respect to respiratory therapy should be covered as a home health benefit under title XVIII of the Social Security Act.

Section 31(g) requires the Secretary to conduct a study involving a comprehensive analysis of the cost effects of alternative approaches to improving coverage under title XVIII of the Social Security Act for the treatment of various types of foot conditions.

Section 31(h) directs the Secretary to submit a report (including any legislative recommendations) on each of the demonstration projects and studies described in subsections (a), (c), (d), (f), and (g) of section 31 of the bill, and requires each report to be submitted within 24 months of the date of enactment.

Section 31(i) requires grants, payments under contracts, and other expenditures made for studies and demonstration projects under section 31 to be made in appropriate part from the Federal Hospital

Insurance Trust Fund (established by section 1817 of the Social Security Act) and the Federal Supplementary Medical Insurance Trust Fund (established by section 1841 of the Social Security Act).

Section 32. Provider Reimbursement Review Board

Section 32 amends section 1878(f)(1) of the Social Security Act to specify the right of providers to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider) that it is without authority to decide the question, by a civil action commenced within 60 days of the date on which the Board's determination is rendered. The Board is required to render a determination requested by a provider within 30 days of the date of the request, and such determination is not subject to review by the Secretary.

Section 33. Access to Books and Records of Subcontractors

Section 33 of the bill amends section 1861(v)(1) of the Social Security Act by adding a new subparagraph (H), which prohibits Medicare reimbursement for amounts incurred by providers under contracts for services unless such contracts contain a clause requiring subcontractors to make available (for three years following the date such services are furnished) upon request to the Secretary or the Comptroller General (or any of their duly authorized representatives), the contract and books, documents, and records of the subcontractor necessary to verify the nature and extent of costs. The provision applies to services furnished pursuant to a contract entered into after the date of enactment of the bill, the value or cost of which is $10,000 or more over a 12 month period.

VI. Changes in Existing Law Made by the Bill, as Reported

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

Social Security Act

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TITLE II—FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

* * * * * * *

ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS

Sec. 226.
(a) * * *

* * * * * * *

(b) Every individual who—
(1) has not attained age 65, and

(2)(A) is entitled to, and has for 24 [consecutive] calendar months been entitled to, (i) disability insurance benefits under section 223 or (ii) child's insurance benefits under section 202(d) by reason of a disability (as defined in section 223(d)) or (iii) widow's insurance benefits under section 202(e) or widower's insurance benefits under section 202(f) by reason of a disability (as defined in section 223(d)), or (B) is, and has been for not less than 24 [consecutive] months a disabled qualified railroad retirement beneficiary, within the meaning of section 7(d) of the Railroad Retirement Act of 1974,

shall be entitled to hospital insurance benefits under part A of title XVIII for each month beginning with the later of (I) July 1973 or (II) the twenty-fifth [consecutive] month of his entitlement or status as a qualified railroad retirement beneficiary described in paragraph (2), and ending with the month following the month in which notice of termination of such entitlement to benefits or status as a qualified railroad retirement beneficiary described in paragraph (2) is mailed to him, or if earlier, with the month before the month in which he attains age 65.

(c) For purposes of subsection (a)—

(1) entitlement of an individual to hospital insurance benefits for a month shall consist of entitlement to have payment made under, and subject to the limitations in, part A of title XVIII on his behalf for inpatient hospital services, post-hospital extended care services, [and post-hospital home health services] *and home health services* (as such terms are defined in part C of title XVIII) furnished him in the United States (or outside the United States in the case of inpatient hospital services furnished under the conditions described in section 1814(f)) during such month; except that (A) no such payment may be made for post-hospital extended care services furnished before January 1967, and (B) no such payment may be made for post-hospital extended care services [or post-hospital home health services] unless the discharge from the hospital required to qualify such services for payment under part A of title XVIII occurred (i) after June 30, 1966, or on or after the first day of the month in which he attains age 65, whichever is later, or (ii) if he was entitled to hospital insurance benefits pursuant to subsection (b), at a time when he was so entitled; and

* * * * * * *

(f) For purposes of subsection (b) (and for purposes of section 1837(g)(1) of this Act and section 7(d)(2)(ii) of the Railroad Retirement Act of 1974), the 24 months for which an individual has to have been entitled to specified monthly benefits on the basis of disability in order to become entitled to hospital insurance benefits on such basis effective with any particular month (or to be deemed to have enrolled in the supplementary medical insurance program, on the basis of such entitlement, by reason of section 1837(f)), where such individual had been entitled to specified monthly benefits of the same type during a previous period which terminated—

(1) more than 60 months before that particular month in any case where such monthly benefits were of the type specified in clause (A)(i) or (B) of subsection (b)(2), or

(2) more than 84 months before that particular month in any case where such monthly benefits were of the type specified in clause (A)(ii) or (A)(iii) of such subsection,

shall not include any month which occurred during such previous period.

[(f)] *(g)* For entitlement to hospital insurance benefits in the case of certain uninsured individuals, see section 103 of the Social Security Amendments of 1965.

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TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

Part A—Hospital Insurance Benefits for the Aged and Disabled

DESCRIPTION OF PROGRAM

Sec. 1811. The insurance program for which entitlement is established by sections 226 and 226A provides basic protection against the costs of hospital [and related post-hospital services], *related post-hospital, and home health services* in accordance with this part for (1) individuals who are age 65 or over and are entitled to retirement benefits under title II of this Act or under the railroad retirement system, (2) individuals under age 65 who have been entitled for not less than 24 [consecutive] months to benefits under title II of this Act or under the railroad retirement system on the basis of a disability, and (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease.

SCOPE OF BENEFITS

Sec. 1812. (a) The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf or, in the case of payments referred to in section 1814(d)(2) to him (subject to the provisions of this part) for—

(1) inpatient hospital services for up to 150 days during any spell of illness minus one day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);

(2) post-hospital extended care services for up to 100 days during any spell of illness; and

[(3) post-hospital home health services for up to 100 visits (during the one-year period described in section 1861(n)) after the beginning of one spell of illness and before the beginning of the next.]

(3) home health services.

* * * * * * *

[(d) Payment under this part may be made for post-hospital home health services furnished an individual only during the one-year period described in section 1861(n) following his most recent hospital discharge which meets the requirements of such section, and only for the first 100 visits in such period. The number of visits to be charged for purposes of the limitation in the preceding sentence, in connection with items or services described in section 1861(m), shall be determined in accordance with regulations.]

(e) For purposes of subsections [(b), (c), and (d)] *(b) and (c)* inpatient hospital services, inpatient psychiatric hospital services, [post-hospital extended care services, and post-hospital home health services] *and post-hospital extended care services* shall be taken into account only if payment is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1814(a), made with respect to such services under this part.

(f) For definition of "spell of illness", and for definitions of other terms used in this part, see section 1861.

* * * * * * *

CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

Requirement of Requests and Certifications

SEC. 1814. (a) Except as provided in subsections (d) and (g) and in section 1876, payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1866 and only if—

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner, and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year;

(2) physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that—

(A) in the case of inpatient psychiatric hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the psychiatric treatment of an individual; and (i) such treatment can or could reasonably be expected to improve the condition for which such treatment is or was necessary or

(ii) inpatient diagnostic study is or was medically required and such services are or were necessary for such purposes;

(B) in the case of inpatient tuberculosis hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the treatment of an individual for tuberculosis; and such treatment can or could reasonably be expected to (i) improve the condition for which such treatment is or was necessary or (ii) render the condition noncommunicable;

(C) in the case of post-hospital extended care services, such services are or were required to be given because the individual needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1861(e)) prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services;

(D) in the case of [post-hospital] home health services, such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)), and needed skilled nursing care on an intermittent basis, or physical, *occupational*, or speech therapy [, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1861(e)) or post-hospital extended care services]; a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; and such services are or were furnished while the individual was under the care of a physician; or

(E) in the case of inpatient hospital services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, the individual, because of his underlying medical condition and clinical status *or because of the severity of the dental procedure*, requires hospitalization in connection with the provision of such [dental] services;

(3) with respect to inpatient hospital services (other than inpatient psychiatric hospital services and inpatient tuberculosis hospital services) which are furnished over a period of time, a physician certifies that such services are required to be given on

an inpatient basis for such individual's medical treatment, or that inpatient diagnostic study is medically required and such services are necessary for such purpose, except that (A) such certification shall be furnished only in such cases, with such frequency, and accompanied by such supporting material, appropriate to the cases involved, as may be provided by regulations, and (B) the first such certification required in accordance with clause (A) shall be furnished no later than the 20th day of such period;

(4) in the case of inpatient psychiatric hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving (A) intensive treatment services, (B) admission and related services necessary for a diagnostic study, or (C) equivalent services;

(5) in the case of inpatient tuberculosis hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving treatment which could reasonably be expected to (A) improve his condition or (B) render it noncommunicable;

(6) with respect to inpatient hospital services furnished such individual after the 20th day of a continuous period of such services and with respect to post-hospital extended care services furnished after such day of a continuous period of such services as may be prescribed in or pursuant to regulations, there was not in effect, at the time of admission of such individual to the hospital or skilled nursing facility, as the case may be, a decision under section 1866(d) (based on a finding that utilization review of long-stay cases is not being made in such hospital or facility): and

(7) with respect to inpatient hospital services or post-hospital extended care services furnished such individual during a continuous period, a finding has not been made (by the physician members of the committee or group, as described in section 1861 (k) (4), including any finding made in the course of a sample or other review of admissions to the institution) pursuant to the system of utilization to review that further inpatient hospital services or further post-hospital extended care services, as the case may be, are not medically necessary; except that, if such a finding has been made, payment may be made for such services furnished before the 4th day after the day on which the hospital or skilled nursing facility, as the case may be, received notice of such finding.

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician makes certification of the kind provided in subparagraph (A), (B), (C), (D), or (E) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. *With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which*

shall become effective no later than June 30, 1980, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan.

Amount Paid to Providers

[(b)(1) The amount paid to any provider of services with respect to services for which payment may be made under this part shall, subject to the provisions of section 1813, be—

[(1) the lesser of (A) the reasonable cost of such services, as determined under section 1861(v) and as further limited by section 1881(b)(2)(B), or (B) the customary charges with respect to such services; or

[(2) if such services are furnished by a public provider of services free of charge or at nominal charges to the public, the amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such reasonable cost which the Secretary finds will provide fair compensation to such provider for such services.]

(b) The amount paid to any provider of services with respect to services for which payment may be made under this part shall, subject to the provisions of section 1813, be the reasonable cost of such services, as determined under section 1861(v) and as further limited by section 1881(b)(2)(B).

No Payments to Federal Providers of Services

(c) Subject to section 1880, no payment may be made under this part (except under subsection (d) or subsection [(i)] *(h)*) to any Federal provider of services, except a provider of services which the Secretary determines is providing services to the public generally as a community institution or agency; and no such payment may be made to any provider of services for any item or service which such provider is obligated by a law of, or a contract with, the United States to render at public expense.

* * * * * * *

[Payment for Posthospital Extended Care Services

[(h)(1) An individual shall be presumed to require the care specified in subsection (a)(2)(C) of this section for purposes of making payment to an extended care facility (subject to the provisions of section 1812) for posthospital extended care services which are furnished by such facility to such individual if—

[(A) the certification referred to in subsection (a)(2)(C) of this section is submitted prior to or at the time of admission of such individual to such extended care facility,

[(B) such certification states that the medical condition of the individual is a condition designated in regulations,

[(C) such certification is accompanied by a plan of treatment for providing such services, and

[(D) there is compliance with such other requirements and procedures as may be specified in regulations,

but only for services furnished during such limited periods of time with respect to such conditions of the individual as may be prescribed in regulations by the Secretary, taking into account the medical severity of such conditions, the degree of incapacity, and the minimum length of stay in an institution generally needed for such conditions, and such other factors affecting the type of care to be provided as the Secretary deems pertinent.

[(2) If the Secretary determines with respect to a physician that such physician is submitting with some frequency (A) erroneous certifications that individuals have conditions designated in regulations as provided in this subsection or (B) plans for providing services which are inappropriate, the provisions of paragraph (1) shall not apply, after the effective date of such determination, in any case in which such physician submits a certification or plan referred to in subparagraph (A), (B), or (C) of paragraph (1).

[Payment for Posthospital Home Health Services

[(i)(1) An individual shall be presumed to require the services specified in subsection (a)(2)(D) of this section for purposes of making payment to a home health agency (subject to the provisions of section 1812) for posthospital home health services furnished by such agency to such individual if—

[(A) the certification and plan referred to in subsection (a)(2)(D) of this section are submitted in timely fashion prior to the first visit by such agency,

[(B) such certification states that the medical condition of the individual is a condition designated in regulations, and

[(C) there is compliance with such other requirements and procedures as may be specified in regulations,

but only for services furnished during such limited numbers of visits with respect to such conditions of the individual as may be prescribed in regulations by the Secretary, taking into account the medical severity of such conditions, the degree of incapacity, and the minimum period of home confinement generally needed for such conditions, and such other factors affecting the type of care to be provided as the Secretary deems pertinent.

[(2) If the Secretary determines with respect to a physician that such physician is submitting with some frequency (A) erroneous certifications that individuals have conditions designated in regulations as provided in this subsection or (B) plans for providing services which are inappropriate, the provisions of paragraph (1) shall not apply after the effective date of such determination, in any case in which such physician submits a certification or plan referred to in subparagraph (A) or (B) of paragraph (1).]

Payment for Certain Hospital Services Provided in Veterans' Administration Hospitals

[(i)](h)(1) Payments shall also be made to any hospital operated by the Veterans' Administration for inpatient hospital services fur-

nished in a calendar year by the hospital, or under arrangements (as defined in section 1861(w)) with it, to an individual entitled to hospital benefits under section 226 even though the hospital is a Federal provider of services if (A) the individual was not entitled to have the services furnished to him free of charge by the hospital, (B) the individual was admitted to the hospital in the reasonable belief on the part of the admitting authorities that the individual was a person who was entitled to have the services furnished to him free of charge, (C) the authorities of the hospital, in admitting the individual, and the individual, acted in good faith, and (D) the services were furnished during a period ending with the close of the day on which the authorities operating the hospital first became aware of the fact that the individual was not entitled to have the services furnished to him by the hospital free of charge, or (if later) ending with the first day on which it was medically feasible to remove the individual from the hospital by discharging him therefrom or transferring him to a hospital which has in effect an agreement under this title.

(2) Payment for services described in paragraph (1) shall be in an amount equal to the charge imposed by the Veterans' Administration for such services, or (if less) the reasonable costs for such services (as estimated by the Secretary). Any such payment shall be made to the entity to which payment for the services involved would have been payable, if payment for such services had been made by the individual receiving the services involved (or by another private person acting on behalf of such individual).

* * * * * * *

USE OF PUBLIC AGENCIES OR PRIVATE ORGANIZATIONS TO FACILITATE PAYMENT TO PROVIDERS OF SERVICES

SEC. 1816. (a) * * *

* * * * * * *

(e)(1) Notwithstanding subsections (a) and (d), the Secretary, after taking into consideration any preferences of providers of services, may assign or reassign any provider of services to any agency or organization which has entered into an agreement with him under this section, if he determines, after applying the standards, criteria, and procedures developed under subsection (f), that such assignment or reassignment would result in the more effective and efficient administration of this part.

(2) Notwithstanding subsections (a) and (d), the Secretary may (*subject to the provisions of paragraph (4)*) designate a national or regional agency or organization which has entered into an agreement with him under this section to perform functions under the agreement with respect to a class of providers of services in the Nation or region (as the case may be), if he determines, after applying the standards, criteria, and procedures developed under subsection (f), that such designation would result in more effective and efficient administration of this part.

(3)(A) Before the Secretary makes an assignment or reassignment under paragraph (1) of a provider of services to other than the agency or organization nominated by the provider, he shall furnish (i) the provider and such agency or organization with a full explanation of

the reasons for his determination as to the efficiency and effectiveness of the agency or organization to perform the functions required under this part with respect to the provider, and (ii) such agency or organization with opportunity for a hearing, and such determination shall be subject to judicial review in accordance with chapter 7 of title 5, United States Code.

(B) Before the Secretary makes a designation under paragraph (2) with respect to a class of providers of services, he shall furnish (i) such providers and the agencies and organizations adversely affected by such designation with a full explanation of the reasons for his determination as to the efficiency and effectiveness of such agencies and organizations to perform the functions required under this part with respect to such providers, and (ii) the agencies and organizations adversely affected by such designation with opportunity for a hearing, and such determination shall be subject to judicial review in accordance with chapter 7 of title 5, United States Code.

(4) Notwithstanding subsections (a) and (d) and paragraphs (1), (2), and (3) of this subsection, the Secretary shall designate regional agencies or organizations which have entered into an agreement with him under this section to perform functions under such agreement with respect to home health agencies (as defined in section 1861(o)) in the region, except that in assigning such agencies to such designated regional agencies or organizations the Secretary shall assign a home health agency which is a subdivision of a hospital (and such agency and hospital are affiliated or under common control) only if, after applying such criteria relating to administrative efficiency and effectiveness as he shall promulgate, he determines that such assignment would result in the more effective and efficient administration of this title.

* * * * * * *

Part B—Supplementary Medical Insurance Benefits for the Aged and Disabled

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scope of benefits

Sec. 1832. (a) The benefits provided to an individual by the insurance program established by this part shall consist of—

(1) entitlement to have payment made to him or on his behalf (subject to the provisions of this part) for medical and other health services, except those described in subparagraphs (B) and (D) of paragraph (2); and

(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

(A) home health services [for up to 100 visits during a calendar year];

(B) medical and other health services furnished by a provider of services or by others under arrangement with them made by a provider of services, excluding—

(i) physician services except where furnished by—

(I) a resident or intern of a hospital, [or]

(II) a physician to a patient in a hospital which has a teaching program approved as specified in paragraph (6) of section 1861(b) (including services in conjunction with the teaching programs of such hospital whether or not such patient is an inpatient of such hospital), unless either clause (A) or (B) of paragraph (7) of such section is met, [and] *or*

(III) a physician to a patient in a community mental health center or to a patient in a comprehensive outpatient rehabilitation facility; and

(ii) services for which payment may be made pursuant to section 1835(b)(2); and

(C) outpatient physical therapy services, other than services to which the next to last sentence of section 1861(p) applies; [and]

(D) rural health clinic services[.]*;*

(E) community mental health center services;

(F) comprehensive outpatient rehabilitation facility services; and

(G) facility services furnished in connection with surgical procedures specified by the Secretary pursuant to section 1833(i)(1) and performed in an ambulatory surgical center (which meets health, safety, and other standards specified by the Secretary in regulations).

* * * * * * *

PAYMENT OF BENEFITS

SEC. 1833. (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1832(a)(1)—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), (B) with respect to expenses incurred for radiological or pathological services for which payment may be made under this part, furnished to an inpatient of a hospital by a physician in the field of radiology or pathology *who has in effect an agreement with the Secretary by which the physician agrees to accept an assignment (as provided for in sec-*

tion 1842(b)(3)(B)(ii)) for all physicians' services furnished by him for hospital inpatients enrolled under this part, the amounts paid shall be equal to 100 percent of the reasonable charges for such services, (C) with respect to expenses incurred, for those physicians' services for which payment may be made under this part that are described in section 1862(a)(4), the amounts paid shall be subject to such limitations as may be prescribed by regulations, (D) with respect to diagnostic tests performed in a laboratory for which payment is made under this part to the laboratory, the amounts paid shall be equal to 100 percent of the negotiated rate for such tests (as determined pursuant to subsection (g) of this section), [and] (E) with respect to services furnished to individuals who have been determined to have end stage renal disease, the amounts paid shall be determined subject to the provisions of section 1881, *(F) with respect to expenses incurred for preadmission diagnostic radiological or pathological services for which payment may be made under this part and which are furnished to an individual by the outpatient department of a hospital within seven days of such individual's admission to the same hospital as an inpatient or, to the extent practicable as determined by regulations prescribed by the Secretary, to another hospital by a physician in the field of radiology or pathology who has an agreement in effect with the Secretary by which the physician agrees to accept an assignment (as provided for in section 1842(b)(3)(B)(ii)) for all physicians' services furnished by him for such services to individuals enrolled under this part, the amounts paid shall be equal to the reasonable charges for such services, and (G) with respect to items and services described in section 1861(s)(10), the amounts paid shall be 100 percent of the reasonable charges for such items and services, and*

[(2) in the case of services described in section 1832(a)(2) (except those services described in subparagraph (D) of section 1832(a)(2))—with respect to home health services, 100 percent, and with respect to other services (unless otherwise specified in section 1881), 80 percent of—

[(A) the lesser of (i) the reasonable cost of such services, as determined under section 1861(v), or (ii) the customary charges with respect to such services; or

[(B) if such services are furnished by a public provider of services free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2); or

[(C) if such services are services to which the next to last sentence of section 1861(p) applies, the reasonable charges for such services, and

[(3) in the case of services described in section 1832(a)(2)(D), 80 percent of costs which are reasonable and related to the cost of furnishing such services or on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A).]

(2) in the case of services described in section 1832(a)(2) (except those services described in subparagraphs (D), (E), (F),

and (G) of such section and in paragraph (5) of this subsection)—

(A) with respect to home health services and to items and services described in section 1861(s)(10), the reasonable cost of such services, as determined under section 1861(v);

(B) with respect to other services (except those described in subparagraph (C) of this paragraph), the reasonable costs of such services, as so determined, less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such other services (other than for items and services described in section 1861(s)(10)) exceed 80 percent of such costs;

(C) with respect to services described in the second sentence of section 1861(p), 80 percent of the reasonable charges for such services;

(3) in the case of services described in subparagraphs (D), (E), and (F) of section 1832(a)(2), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services exceed 80 percent of such costs; and

(4) in the case of facility services described in subparagraph (G) of section 1832(a)(2), the applicable amount described in subparagraph (A) of section 1833(i)(2); and

(5) in the case of preadmission diagnostic services described in section 1861(s)(2)(C) which are furnished to an individual by the outpatient department of a hospital within 7 days of such individual's admission to the same hospital as an inpatient or (to the extent practicable as determined by regulations prescribed by the Secretary) to another hospital, the reasonable costs for such services.

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of $60; except that (1) the amount of the deductible for such calendar year as so determined shall first be reduced by the amount of any expenses incurred by such individual in the last three months of the preceding calendar year and applied toward such individual's deductible under this section for such preceding year, [and] (2) such total amount shall not include expenses incurred for *(A)* radiological or pathological services furnished to such individual as an inpatient of a hospital by a physician in the field of radiology or pathology *who has in effect an agreement with the Secretary by which the physician agrees to accept an assignment (as provided for in section 1842(b)(3)(B)(ii)) for all physicians' services furnished by him for hospital inpatients enrolled under this part, or (B) for items and services described in section 1861(s)(10), and (3)*

such deductible shall not apply with respect to home health services. The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence.

(c) Notwithstanding any other provision of this part, with respect to expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital *and not a patient of a community mental health center* at the time such expenses are incurred, [there] *not more than $937.50* shall be considered as incurred expenses for purposes of subsections (a) and (b) [only whichever of the following amounts is the smaller:

[(1) $312.50, or

[(2) 62½ percent of such expenses.].

* * * * * * *

(g) In the case of services described in the next to last sentence of section 1861(p), with respect to expenses incurred in any calendar year, no more than [$100] *$500* shall be considered as incurred expenses for purposes of subsections (a) and (b).

[(g)] *(h)* With respect to diagnostic tests performed in a laboratory for which payment is made under this part to the laboratory, the Secretary is authorized to establish a payment rate which is acceptable to the laboratory and which would be considered the full charge for such tests. Such negotiated rate shall be limited to an amount not in excess of the total payment that would have been made for the services in the absence of such a rate.

(i)(1) The Secretary shall, in consultation with the National Professional Standards Review Council and appropriate medical organizations, specify surgical procedures which are appropriately (when considered in terms of the proper utilization of hospital inpatient facilities) performed on an inpatient basis in a hospital but which also can be performed safely on an ambulatory basis in an ambulatory surgical center or hospital outpatient department.

(2)(A) The amount of payment to be made for facility services furnished in connection with surgical procedures specified pursuant to paragraph (1) and furnished to an individual in an ambulatory surgical center shall be equal to an amount established by the Secretary with respect to each such procedure which (i) takes into account the costs incurred by such centers, or classes of centers, generally in

providing the services appropriate for the performance of such services, and (ii) takes such costs into account in such a manner which will assure that the performance of the service in such an ambulatory surgical center will result in substantially less amounts paid under this title than would have been paid if the services had been furnished on an inpatient basis. The amount so established shall be reviewed periodically and may be adjusted, when appropriate, to take account of varying conditions in different areas.

(B) The amount of payment to be made under this part for services (including all pre- and post-operative services) described in paragraphs (1) and (2)(A) of section 1861(s) and furnished in connection with surgical procedures (specified pursuant to paragraph (1) of this subsection) in an ambulatory surgical center or a hospital outpatient department shall be the reasonable charge for such services if the physician accepts an assignment, as provided for in section 1842(b)(3)(B)(ii), with respect to such payment.

[LIMITATION ON HOME HEALTH SERVICES

[SEC. 1834. (a) Payment under this part may be made for home health services furnished an individual during any calendar year only for 100 visits during such year. The number of visits to be charged for purposes of the limitation in the preceding sentence, in connection with items and services described in section 1861(m), shall be determined in accordance with regulations.

[(b) For purposes of subsection (a), home health services shall be taken into account only if payment under this part is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1835(a), made with respect to such services.]

LIMITATION ON COMMUNITY MENTAL HEALTH CENTER SERVICES

SEC. 1834. Payment under this part may be made for community mental health center services furnished an individual for—

(1) up to 15 outpatient visits during any calendar year; and

(2) up to 60 partial hospitalization visits to such a center during any calendar year.

Services shall be taken into account for purposes of paragraphs (1) and (2) only if payment is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1835(a), made with respect to such services under this part.

PROCEDURE FOR PAYMENT OF CLAIMS OF PROVIDERS OF SERVICES

SEC. 1835. (a) Except as provided in subsections (b), (c), and (e), payment for services described in section 1832(a)(2) furnished an individual may be made only to providers of services which are eligible therefor under section 1866(a), and only if—

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner and

by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that, where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year; and

(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations) that—

(A) in the case of home health services (i) such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needed skilled nursing care on an intermittent basis, or physical, *occupational*, or speech therapy, (ii) a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

(B)(*i*) in the case of medical and other health services except services described in subparagraphs (B), (C), and (D) of section 1861(s)(2), such services are or were medically required; [and]

(*ii*) *in the case of services furnished by a physician described in section 1861(r)(6) to an individual described in such section, such services are or were required for the treatment of mental, psychoneurotic, or personality disorders;*

(C) in the case of outpatient physical therapy services, (i) such services are or were required because the individual needed physical therapy services, (ii) a plan for furnishing such services has been established, and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

(D) in the case of outpatient speech pathology services, (i) such services are or were required because the individual needed speech pathology services, (ii) a plan for furnishing such services has been established *by a physician or by the speech pathologist providing such services* and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician[.]*;*

(*E*) *in the case of community mental health center services, (i) such services are or were required in connection with the treatment of mental, psychoneurotic, or personality disorders, (ii) a plan for furnishing such services has been established by a physician (as defined in section 1861(r)(1)) or qualified mental health professional (as defined in section 1861(bb)(3)) and is periodically reviewed and approved by a physician, (iii) such services are or were furnished while the individual is or was under the case management of a phy-*

sician (as defined in section 1861(r)(1)), and (iv) in the case of services provided with respect to a partial hospitalization visit, the individual would otherwise require or have required (in the professional judgment of such physician) inpatient psychiatric services;

(F) in the case of comprehensive outpatient rehabilitation facility services, (i) such services are or were required because the individual needed skilled rehabilitation services, (ii) a plan for furnishing such services has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician: and

(G) in the case of services furnished in connection with surgical procedures, specified pursuant to section 1833(i)(1), in an ambulatory surgical center, such services are or were medically required.

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where at a later date, a physician makes a certification of the kind provided in subparagraph (A) or (B) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. For purposes of this section, the term "provider of services" shall include a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A), or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B), but only with respect to the furnishing of outpatient physical therapy services (as therein defined). *With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than June 30, 1980, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan.*

* * * * * * *

ENROLLMENT PERIODS

SEC. 1837. (a) An individual may enroll in the insurance program established by this part only in such manner and form as may be prescribed by regulations, and only during an enrollment period prescribed in or under this section.

[(b) No individual may enroll under this part more than twice.]

* * * * * * *

(e) There shall be a general enrollment period[, after the period described in subsection (c), during the period beginning on January 1 and ending on March 31 of each year beginning with 1969] *which is any period after the period described in subsection (c).*

* * * * * * *

(g) All of the provisions of this section shall apply to individuals satisfying subsection (f), except that—

(1) in the case of an individual who satisfies subsection (f) by reason of entitlement to disability insurance benefits described in section 226(a)(2)(B), his initial enrollment period shall begin on the first day of the later of (A) April 1973 or (B) the third month before the 25th [consecutive] month of such entitlement, and shall reoccur with each continuous period of eligibility (as defined in section 1839(e)) and upon attainment of age 65;

(2)(A) in the case of an individual who is entitled to monthly benefits under section 202 or 223 on the first day of his initial enrollment period or becomes entitled to monthly benefits under section 202 during the first 3 months of such period, his enrollment shall be deemed to have occurred in the third month of his initial enrollment period, and

(B) in the case of an individual who is not entitled to benefits under section 202 on the first day of his initial enrollment period and does not become so entitled during the first 3 months of such period, his enrollment shall be deemed to have occurred in the month in which he files the application establishing his entitlement to hospital insurance benefits provided such filing occurs during the last 4 months of his initial enrollment period; and

(3) in the case of an individual who would otherwise satisfy subsection (f) but does not establish his entitlement to hospital insurance benefits until after the last day of his initial enrollment period (as defined in subsection (d) of this section), his enrollment shall be deemed to have occurred on the first day of [the earlier of the then current or immediately succeeding general enrollment period (as defined in subsection (e) of this section)] *the month in which the individual files an application establishing such entitlement.*

* * * * * * *

COVERAGE PERIOD

SEC. 1838. (a) The period during which an individual is entitled to benefits under the insurance program established by this part (hereinafter referred to as his "coverage period") shall begin on whichever of the following is the latest:

(1) July 1, 1966 or (in the case of a disabled individual who has not attained age 65) July 1, 1973, or

(2)(A) in the case of an individual who enrolls pursuant to subsection (d) of section 1837 before the month in which he first satisfies paragraph (1) or (2) of section 1836, the first day of such month, or

(B) in the case of an individual who enrolls pursuant to such subsection (d) in the month in which he first satisfies such paragraph, the first day of the month following the month in which he so enrolls, or

(C) in the case of an individual who enrolls pursuant to such subsection (d) in the month following the month in which he first satisfies such paragraph, the first day of the second month following the month in which he so enrolls, or

(D) in the case of an individual who enrolls pursuant to such subsection (d) more than one month following the month in which he satisfies such paragraph, the first day of the third month following the month in which he so enrolls, or

(E) in the case of an individual who enrolls pursuant to subsection (e) of section 1837, [the July 1] *the first day of the third month* following the month in which he so enrolls; or

* * * * * * *

(b) An individual's coverage period shall (*except as otherwise provided in section 1843(e)*) continue until his enrollment has been terminated—

(1) by the filing of notice that the individual no longer wishes to participate in the insurance program established by this part, or

(2) for nonpayment of premiums.

The termination of a coverage period under paragraph (1) shall take effect at the close of the calendar quarter following the calendar quarter in which the notice is filed. The termination of a coverage period under paragraph (2) shall take effect on a date determined under regulations, which may be determined so as to provide a grace period in which overdue premiums may be paid and coverage continued. The grace period determined under the preceding sentence shall not exceed 90 days; except that it may be extended to not to exceed 180 days in any case where the Secretary determines that there was good cause for failure to pay the overdue premiums within such 90-day period.

Where an individual who is deemed to have enrolled for medical insurance pursuant to section 1837(f) files a notice before the first day of the month in which his coverage period begins advising that he does not wish to be so enrolled, the termination of the coverage period resulting from such deemed enrollment shall take effect with the first day of the month the coverage would have been effective and such notice shall not be considered a disenrollment for the purposes of section 1837(b). Where an individual who is deemed enrolled for medical insurance benefits pursuant to section 1837(f) files a notice requesting termination of his deemed coverage in or after the month in which such coverage becomes effective, the termination of such coverage shall take effect at the close of the calendar quarter following the calendar quarter in which the notice is filed.

* * * * * * *

AMOUNTS OF PREMIUMS

SEC. 1839. (a) * * *

* * * * * * *

(d) In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to subsection (c) or (d) of section 1837), the monthly premium determined under subsection (b) or (c) shall be increased by 10 percent of the monthly premium so determined for each full 12 months (in the same continuous period of eligibility) in which he could have been but was not enrolled*; except that in no case may the total amount of such increase exceed 30 percent of such monthly*

premium so determined. For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who [enrolls for a second time) (2) the months which elapsed between the date of the termination of his first coverage period and the close of the enrollment period in which he enrolled for the second time] *reenrolls*) (2) *the months which elapsed between the date of termination of a previous enrollment and the date of the subsequent reenrollment.* Any increase in an individual's monthly premium under the first sentence of this subsection with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which such individual may have.

* * * * * * *

STATE AGREEMENTS FOR COVERAGE OF ELIGIBLE INDIVIDUALS WHO ARE RECEIVING MONEY PAYMENTS UNDER PUBLIC ASSISTANCE PROGRAMS (OR ARE ELIGIBLE FOR MEDICAL ASSISTANCE)

SEC. 1843. (a) * * *

* * * * * * *

(e) Any individual whose coverage period attributable to the State agreement is terminated pursuant to subsection (d)(3) shall be deemed for purposes of this part (including the continuation of his coverage period under this part) to have enrolled under section 1837 in the initial general enrollment period provided by section 1837(c). *The coverage period under this part of any such individual who (in the last month of his coverage period attributable to the State agreement or in any of the following six months) files notice that he no longer wishes to participate in the insurance program established by this part, shall terminate at the close of the month in which the notice is filed.*

* * * * * * *

(g)(1) The Secretary shall, at the request of a State made before January 1, 1970, enter into a modification of an agreement entered into with such State pursuant to subsection (a) under which the second sentence of subsection (b) shall not apply with respect to such agreement.

(2) In the case of any individual who would (but for this subsection) be excluded from the applicable coverage group described in subsection (b) by the second sentence of such subsection—

(A) subsections (c) and (d)(2) shall be applied as if such subsections referred to the modification under this subsection (in lieu of the agreement under subsection (a)), *and*

(B) subsection (d)(3)(B) shall not apply so long as there is in effect a modification entered into by the State under this subsection [, and].

[(C) notwithstanding subsection (e), in the case of any termination described in such subsection, such indivdual may terminate his enrollment under this part by the filing of a notice, before the close of the third month which begins after the date of such

termination, that he no longer wishes to participate in the insurance program established by this part (and in such a case, the termination of his coverage period under this part shall take effect as of the close of such third month).]

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Part C—Miscellaneous Provisions

definition of services, institutions, etc.

Sec. 1861. For purposes of this title—

Spell of Illness

(a) * * *

* * * * * * *

Hospital

(e) The term "hospital" (except for purposes of sections 1814(d), 1814(f) and 1835(b), subsection (a)(2) of this section, paragraph (7) of this subsection, and [subsections (i) and (n)] *subsection (i)* of this section) means an institution which—

(1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(2) maintains clinical records on all patients;

(3) has bylaws in effect with respect to its staff or physicians;

(4) has a requirement that every patient must be under the care of a physician;

(5) provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times except that until January 1, 1979, the Secretary is authorized to waive the requirement of this paragraph for any one-year period with respect to any institution, insofar as such requirement relates to the provision of twenty-four-hour nursing service rendered or supervised by a registered professional nurse (except that in any event a registered professional nurse must be present on the premises to render or supervise the nursing service provided, during at least the regular daytime shift), where immediately preceding such one-year period he finds that—

(A) such institution is located in a rural area and the supply of hospital services in such area is not sufficient to meet the needs of individuals residing therein,

(B) the failure of such institution to qualify as a hospital would seriously reduce the availability of such services to such individual, and

(C) such institution has made and continues to make a good faith effort to comply with this paragraph, but such compliance is impeded by the lack of qualified nursing personnel in such area;

(6) has in effect a hospital utilization review plan which meets the requirements of subsection (k);

(7) in the case of an institution in any State in which State or applicable local law provides for the licensing of hospitals, (A) is licensed pursuant to such law or (B) is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing;

(8) has in effect an overall plan and budget that meets the requirements of subsection (z); and

(9) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of the individuals who are furnished services in the institution.

For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. For purposes of sections 1814(d) and 1835(b) (including determination of whether an individual received inpatient hospital services or diagnostic services for purposes of such sections), section 1814(f)(2), and [subsections (i) and (n)] *subsection (i)* of this section, such term includes any institution which (i) meets the requirements of paragraphs (5) and (7) of this subsection, (ii) is not primarily engaged in providing the services described in section 1861(j)(1)(A) and (iii) is primarily engaged in providing, by or under the supervision of individuals referred to in paragraph (1) of section 1861(r) to inpatients diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. For purposes of section 1814(f)(1), such term includes an institution which (i) is a hospital for purposes of sections 1814(d), 1814(f)(2), and 1835(b) and (ii) is accredited by the Joint Commission on Accreditation of Hospitals, or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of the Joint Commission on Accreditation of Hospitals. Notwithstanding the preceding provisions of this subsection, such term shall not, except for purposes of subsection (a)(2), include any institution which is primarily for the care and treatment of mental diseases or tuberculosis unless it is a tuberculosis hospital (as defined in subsection (g)) or unless it is a psychiatric hospital (as defined in subsection (f)). The term "hospital" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to items and services ordinarily furnished by such institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations. For provisions deeming certain requirements of this subsection to be met in the case of accredited institutions, see section 1865. *The term "hospital" also includes a facility of fifty beds or less which is located in an area determined by the Secretary to meet the definition relating to a rural area described in subparagraph (A) of paragraph (5) of this*

subsection and which meets the other requirements of this subsection, except that—

(A) with respect to the requirements for nursing services applicable after December 31, 1978, such requirements shall provide for temporary waiver of the requirements, for such period as the Secretary deems appropriate, where (i) the facility's failure to fully comply with the requirements is attributable to a temporary shortage of qualified nursing personnel in the area in which the facility is located, (ii) a registered professional nurse is present on the premises to render or supervise the nursing service provided during at least the regular daytime shift, and (iii) the Secretary determines that the employment of such nursing personnel as are available to the facility during such temporary period will not adversely affect the health and safety of patients;

(B) with respect to the health and safety requirements promulgated under paragraph (9), such requirements shall be applied by the Secretary to a facility herein defined in such manner as to assure that personnel requirements take into account the availability of technical personnel and the educational opportunities for technical personnel in the area in which such facility is located, and the scope of services rendered by such facility; and the Secretary, by regulations, shall provide for the continued participation of such a facility where such personnel requirements are not fully met, for such period as the Secretary determines that (i) the facility is making good faith efforts to fully comply with the personnel requirements, and (ii) the employment by the facility of such personnel as are available to the facility will not adversely affect the health and safety of patients; and

(C) with respect to the fire and safety requirements promulgated under paragraph (9), the Secretary may (i) waive, for such period as he deems appropriate, specific provisions of such requirements which if rigidly applied would result in unreasonable hardship for such a facility and which, if not applied, would not jeopardize the health and safety of patients, and (ii) may accept a facility's compliance with all applicable State codes relating to fire and safety in lieu of compliance with the fire and safety requirements promulgated under paragraph (9), if he determines that such State has in effect fire and safety codes, imposed by State law, which adequately protect patients.

* * * * * * *

Post-Hospital Extended Care Services

(i) The term "post-hospital extended care services" means extended care services furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer. For purposes of the preceding sentence, items and services shall be deemed to have been furnished to an individual after transfer from a hospital, and he shall be deemed to have been an inpatient in the hospital immediately before transfer therefrom. if he is admitted to the skilled nursing facility—

(A) within [14] *30* days after discharge from such hospital [, or (B) within 28 days after such discharge, in the case of an individual who was unable to be admitted to a skilled nursing facility within such 14 days because of a shortage of appropriate bed space in the geographic area in which he resides, or (C)], *or* *(B)* within such time as it would be medically appropriate to begin an active course of treatment, in the case of an individual whose condition is such that skilled nursing facility care would not be medically appropriate within [14] *30* days after discharge from a hospital;

an individual shall be deemed not to have been discharged from a skilled nursing facility if, within [14] *30* days after discharge therefrom, he is admitted to such facility or any other skilled nursing facility.

* * * * * * *

Utilization Review

(k) A utilization review plan of a hospital or skilled nursing facility shall be considered sufficient if it is applicable to services furnished by the institution to individuals entitled to insurance benefits under this title and if it provides—

(1) for the review, on a sample or other basis, of admissions to the institution, the duration of stays therein, and the professional services (including drugs and biologicals) furnished, (A) with respect to the medical necessity of the services, and (B) for the purpose of promoting the most efficient use of available health facilities and services;

(2) for such review to be made either (A) a staff committee of the institution composed of two or more physicians *(of which at least two must be physicians described in subsection (r)(1) of this section)*, with or without participation of other professional personnel, or (B) a group outside the institution which is similarly composed and (i) which is established by the local medical society and some or all of the hospitals and skilled nursing facilities in the locality, or (ii) if (and for as long as) there has not been established such a group which serves such institution, which is established in such other manner as may be approved by the Secretary;

* * * * * * *

Agreements for Transfer Between Skilled Nursing Facilities and Hospitals

(l) A hospital and a skilled nursing facility *or community mental health center* shall be considered to have a transfer agreement in effect if, by reason of a written agreement between them or (in case the two institutions are under common control) by reason of a written undertaking by the person or body which controls them, there is reasonable assurance that—

(1) transfer of patients will be effected between the hospital and the skilled nursing facility *or community mental health center* whenever such transfer is medically appropriate as determined by the attending physician; and

(2) there will be interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between the institutions, or in determining whether such individuals can be adequately cared for otherwise than in either of such institutions.

Any skilled nursing facility *or community mental health center* which does not have such an agreement in effect, but which is found by a State agency (of the State in which such facility is situated) with which an agreement under section 1864 is in effect (or, in the case of a State in which no such agency has an agreement under section 1864, by the Secretary) to have attempted in good faith to enter into such an agreement with a hospital sufficiently close to the facility to make feasible the transfer between them of the patients and the information referred to in paragraph (2), shall be considered to have such an agreement in effect if and for so long as such agency (or the Secretary, as the case may be) finds that to do so is in the public interest and essential to assuring extended care services for persons in the community who are eligible for payments with respect to such services under this title.

Home Health Services

(m) The term "home health services" means the following items and services furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician, which items and services are, except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual's home—

(1) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

(2) physical, occupational, or speech therapy;

(3) medical social services under the direction of a physician;

(4) to the extent permitted in regulations, part-time or intermittent services of a home health aide *who has successfully completed a training program approved by the Secretary;*

* * * * * * *

[Post-Hospital Home Health Services

[(n) The term "post-hospital home health services" means home health services furnished an individual within one year after his most recent discharge from a hospital of which he was an inpatient for not less than 3 consecutive days or (if later) within one year after his most recent discharge from a skilled nursing facility of which he was an inpatient entitled to payment under part A for post-hospital extended care services, but only if the plan covering the home health services (as described in subsection (m)) is established within 14 days after his discharge from such hospital or skilled nursing facility.]

Home Health Agency

(o) The term "home health agency" means a public agency or private organization, or a subdivision of such an agency or organization, which—

(1) is primarily engaged in providing skilled nursing services and other therapeutic services;

(2) has policies, established by a group of professional personnel (associated with the agency or organization), including one or more physicians and one or more registered professional nurses, to govern the services (referred to in paragraph (1)) which it provides, and provides for supervision of such services by a physician or registered professional nurse;

(3) maintains clinical records on all patients;

(4) in the case of an agency or organization in any State in which State or applicable local law provides for the licensing of agencies or organizations of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing;

(5) has in effect an overall plan and budget that meets the requirements of subsection (z); [and]

(6) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such agency or organization; *and*

(7) *meets such additional requirements (including conditions relating to bonding or establishing of escrow accounts as the Secretary finds necessary for the financial security of the program) as the Secretary finds necessary for the effective and efficient operation of the program;*

[except that such terms shall not include a private organization which is not a nonprofit organization exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1954 (or a subdivision of such organization) unless it is licensed pursuant to State law and it meets such additional standards and requirements as may be prescribed in regulations; and] except that for purposes of part A such term shall not include any agency or organization which is primarily for the care and treatment of mental diseases.

* * * * * * *

Physician

(r) The term "physician," when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)), (2) a doctor of [dentistry or of dental or oral surgery] *dental surgery or of dental medicine* who is legally authorized to practice dentistry by the State in which he performs such function [but only with respect to (A) surgery related to the jaw or any structure continguous to the jaw or (B) the reduction of any fracture of the jaw or any facial bone, or (C) the certification required by section 1814(a)(2)(E) of this Act] *and who is acting within the scope of his license when he performs such functions*, [(3) except for the purposes of section 1814(a), section 1835, and subsections (j), (k), (m), and (o) of this section, a doctor

of podiatry or surgical chiropody, but (unless clause (1) of this subsection also applies to him) only with respect to functions which he is legally authorized to perform as such by the State in which he performs them,] *(3) a doctor of podiatric medicine for the purposes of subsection (s) of this section but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them; and for the purposes of subsections (k) and (m) of this section and sections 1814(a) and 1835 but only if his performance of functions under subsections (k) and (m) and sections 1814(a) and 1835 is consistent with the policy of the institution or agency with respect to which he performs them and with the functions which he is legally authorized to perform,* [or] (4) a doctor of optometry, who is legally authorized to practice optometry by the State in which he performs such function, but only with respect to [establishing the necessity for prosthetic lenses] *services related to the condition of aphakia,* [or] (5) a chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of sections 1861(s)(1) and 1861(s)(2)(A) and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation demonstrated by X-ray *or other chiropractic clinical findings* to exist) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided, *or (6) a clinical psychologist who is licensed as such by the State (or in a State which does not license clinical psychologists as such, is legally authorized to perform the services of a clinical psychologist in the jurisdiction in which he performs such services) and who meets uniform minimum requirements prescribed by the Secretary, but only for the purpose of section 1861(s)(1) and section 1835(a)(2)(B)(ii) and only with respect to the treatment of an individual who is not an inpatient of a hospital (as defined in subsection (e) or (f) of this section), was referred to the psychologist by a physician described in clause (1), and is receiving such services in connection with the treatment of mental psychoneutrotic, or personality disorders and only with respect to services which such clinical psychologist is legally authorized to perform by the State or jurisdiction in which such services are furnished.* For the purposes of section 1862(a)(4) and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice such art in the country in which the inpatient hospital services (referred to in such section 1862(a)(4)) are furnished.

Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services:

(1) physicians' services;

(2)(A) services and supplies (including drugs and biologicals which cannot, as determined in accordance with regulations, be

self-administered) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills;

(B) hospital services (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) incident to physicians' services rendered to outpatients;

(C) diagnostic services which are—

(i) furnished to an individual as an outpatient by a hospital or by others under arrangements with them made by a hospital, and

(ii) ordinarily furnished by such hospital (or by others under such arrangements) to its outpatients for the purpose of diagnostic study;

(D) outpatient physical therapy services;

(E) rural health clinic services; [and]

(F) home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies; *and*

(G) antigens (subject to quantity limitations prescribed in regulations by the Secretary) prepared by a physician, as defined in section 1861(r)(1), for a particular patient, including antigens so prepared which are forwarded to another qualified person (including a rural health clinic) for administration to such patient, from time to time, by or under the supervision of another such physician;

(3)(A) diagnostic X-ray tests (including tests under the supervision of a physician, furnished in a place of residence used as the patient's home, if the performance of such tests meets such conditions relating to health and safety as the Secretary may find necessary), diagnostic laboratory tests, and other diagnostic tests;

(B) diagnostic X-ray tests which are furnished by a physician described in subsection (r)(5) and which are reasonable and necessary in the diagnosis of a subluxation of the spine;

* * * * * * *

(7) ambulance service where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations;

(8) prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care) including replacement of such devices; [and]

(9) leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition[.]*; and*

(10) pneumococcal vaccine and its administration.

No diagnostic tests performed in any laboratory which is independent of a physician's office, a rural health clinic, or a hospital (which, for purposes of this sentence, means an institution considered a hospital for purposes of section 1814(d)) shall be included within paragraph (3) unless such laboratory—

[(10)] (*11*) if situated in any State in which State or applicable local law provides for licensing of establishments of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing establishments of this nature, as meeting the standards established for such licensing; and

[(11)] (*12*) meets such other conditions relating to the health and safety of individuals with respect to whom such tests are performed as the Secretary may find necessary.

There shall be excluded from the diagnostic services specified in paragraph (2)(C) any item or service (except services referred to in paragraph (1)) which—

[(12)] (*13*) would not be included under subsection (b) if it were furnished to an inpatient of a hospital; or

[(13)] (*14*) is furnished under arrangements referred to in such paragraph (2)(C) unless furnished in the hospital or in other facilities operated by or under the supervision of the hospital or its organized medical staff.

None of the items and services referred to in the preceding paragraphs (other than paragraphs (1) and (2)(A)) of this subsection which are furnished to a patient of an institution which meets the definition of a hospital for purposes of section 1814(d) shall be included unless such other conditions are met as the Secretary may find necessary relating to health and safety of individuals with respect to whom such items and services are furnished.

* * * * * * *

Provider of Services

(u) The term "provider of services" means a hospital, *ambulatory surgical center*, skilled nursing facility, *comprehensive outpatient rehabilitation facility*, home health agency, *community mental health center*, or, for purposes of section 1814(g) and section 1835(e), a fund.

Reasonable Cost

(v)(1)(A) * * *

* * * * * * *

(*G*) *In determining such reasonable cost with respect to home health agencies, the Secretary may not include—*

(i) any costs incurred in connection with bonding or establishing an escrow account by any such agency as a result of the financial security requirement described in subsection (o)(7);

(ii) in the case of home health agencies to which the financial security requirement described in subsection (o)(7) applies, any costs attributed to interest charged such an agency in connection with amounts borrowed by the agency to repay overpayments made under this title to the agency, except that such costs may be included in reasonable cost if the Secretary determines that the agency was acting in good faith in borrowing the amounts;

(iii) in the case of contracts entered into by a home health agency after the date of enactment of this subparagraph for the purpose of having services furnished for or on behalf of such

agency, any cost incurred by such agency pursuant to any such contract (I) which is entered into for a period exceeding five years, or (II) which determines the amount payable by the home health agency on the basis of a percentage of the agency's reimbursement or claim for reimbursement for services furnished by the agency; and

(iv) in the case of contracts entered into by a home health agency before the date of enactment of this subparagraph for the purpose of having services furnished for or on behalf of such agency, any cost incurred by such agency pursuant to any such contract, which determines the amount payable by the home health agency on the basis of a percentage of the agency's reimbursement or claim for reimbursement for services furnished by the agency, to the extent that such cost exceeds the reasonable value of the services furnished on behalf of such agency.

(H) In determining such reasonable cost, the Secretary may not include any costs incurred by a provider with respect to any service furnished in connection with matters for which payment may be made under this title and furnished pursuant to a contract between the provider and any of its subcontractors which is entered into after the date of enactment of this subparagraph and the value or cost of which is $10,000 or more over a twelve-month period unless the contract contains a clause to the effect that until the expiration of three years after the furnishing of such services pursuant to such contract, the subcontractor shall make available, upon request, to the Secretary or the Comptroller General of the United States (or any of their duly authorized representatives) the contract, and books, documents, and records of such subcontractor that are necessary to verify the nature and extent of such costs.

Arrangements for Certain Services

(w) (1) The term "arrangements" is limited to arrangements under which receipt of payment by the hospital, a skilled nursing facility, *community mental health center*, or home health agency (whether in its own right or as agent) with respect to services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.

* * * * * * *

Institutional Planning

(z) An overall plan and budget of a hospital, [extended care facility,] *skilled nursing facility, comprehensive outpatient rehabilitation facility*, or home health agency shall be considered sufficient if it—

(1) provides for an annual operating budget which includes all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense items (except that nothing in this paragraph shall require that there be prepared, in connection with any

budget an item by-item identification of the components of each type of anticipated expenditure or income);

(2) provides for a capital expenditures plan for at least a 3-year period (including the year to which the operating budget described in subparagraph (1) is applicable) which includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure in excess of $100,000 related to the acquisition of land, the improvement of land, buildings, and equipment, and the replacement, modernization, and expansion of the buildings and equipment which would, under generally accepted accounting principles, be considered capital items;

(3) provides for review and updating at least annually; and

(4) is prepared, under the direction of the governing body of the institution or agency, by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (if any) of the institution or agency.

* * * * * * *

Rural Health Clinic Services

(aa)(1) The term "rural health clinic services" means—

(A) physicians' services and such services and supplies as are covered under section 1861(s)(2)(A) if furnished as an incident to a physician's professional service *and items and services described in section 1861(s)(10)*

* * * * * * *

Community Mental Health Center Services

(bb)(1) The term "community mental health center services" means the following items and services furnished to an individual as an outpatient by a community mental health center or (to the extent permitted in regulations by the Secretary) by others under arrangements with them made by the center—

(A) diagnostic, therapeutic, or rehabilitative services furnished at the facility and crisis intervention outside the facility, when furnished by a physician (as defined in subsection (r)(1)) or a qualified mental health professional (as defined in paragraph (3));

(B) drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered; and

(C) such items and supplies as are ordinarily furnished to outpatients by community mental health centers in connection with an active mental health program of diagnosis and treatment, excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital.

(2) The term "community mental health center" means a facility which—

(A) meets the definition of a community mental health center under section 201 of the Community Mental Health Centers Act and the regulations prescribed thereunder;

(B) has a requirement that all mental health services are provided under the supervision of a physician or other qualified mental health professional;

(C) meets such requirements as the Secretary may prescribe with respect to staffing requirements and qualifications of the staff;

(D) maintains clinical records on all patients;

(E) has in effect a utilization review plan in accordance with regulations prescribed by the Secretary;

(F) has in effect an agreement with a hospital pursuant to subsection (1);

(G) in the case of a community mental health center in any State in which State or applicable local law provides for the licensing of community mental health centers, is licensed pursuant to such law;

(H) has appropriate procedures or arrangements (in compliance with applicable State and Federal law) for storing, administering, and dispensing drugs and biologicals; and

(I) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such center.

(3) The term "qualified mental health professional" means a clinical psychologist, psychiatric nurse, or psychiatric social worker who has such qualifications as the Secretary shall establish by regulation.

Comprehensive Outpatient Rehabilitation Facility Services

(cc)(1) The term "comprehensive outpatient rehabilitation facility services" means the following items and services furnished by a physician or other qualified professional personnel (as defined in regulations by the Secretary) to an individual who is an outpatient of a comprehensive outpatient rehabilitation facility under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician—

(A) physicians' services;

(B) physical therapy, occupational therapy, speech pathology services, and respiratory therapy;

(C) prosthetic and orthotic devices, including testing, fitting, or training in the use of prosthetic and orthotic devices;

(D) social and psychological services;

(E) nursing care provided by or under the supervision of a registered professional nurse;

(F) drugs and biologicals which cannot, as determined in accordance with regulations, be self administered;

(G) supplies, appliances, and equipment, including the purchase or rental of equipment; and

(H) such other items and services as are medically necessary for the rehabilitation of the patient and are ordinarily furnished by comprehensive outpatient rehabilitation facilities,

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an outpatient of a hospital.

(2) The term "comprehensive outpatient rehabilitation facility" means a facility which—

(A) is primarily engaged in providing (by or under the supervision of physicians) diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons;

(B) provides at least the following comprehensive outpatient rehabilitation services: (i) physicians' services (rendered by physicians, as defined in section 1861(r)(1), who are available at the facility on a full- or part-time basis); (ii) physical therapy; and (iii) social or psychological services;

(C) maintains clinical records on all patients;

(D) has policies established by a group of professional personnel (associated with the facility), including one or more physicians defined in subsection (r)(1) to govern the comprehensive outpatient rehabilitation services it furnishes, and provides for the carrying out of such policies by a full- or part-time physician referred to in subparagraph (B)(i);

(E) has a requirement that every patient must be under the care of a physician;

(F) in the case of a facility in any State in which State or applicable local law provides for the licensing of facilities of this nature (i) is licensed pursuant to such law, or (ii) is approved by the agency of such State or locality, responsible for licensing facilities of this nature, as meeting the standard establishment for such licensing;

(G) has in effect a utilization review plan in accordance with regulations prescribed by the Secretary;

(H) has in effect an overall plan and budget that meets the requirements of subsection (z); and

(I) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such facility, including conditions concerning qualifications of personnel in these facilities.

EXCLUSIONS FROM COVERAGE

SEC. 1862. (a) Notwithstanding any other provisions of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1) which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, *or, in the case of items and services described in section 1861(s)(10), which are not reasonable and necessary for the prevention of illness*;

* * * * * * *

(7) where such expenses are for routine physical checkups, eyeglasses or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during the course of any eye examination) to determine the refractive state of the eyes, hearing aids or examinations therefor, or im-

munizations (*except as otherwise allowed under section 1861(s)(10) and paragraph (1)*);

* * * * * * *

(12) where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under part A in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status *or because of the severity of the dental procedure*, requires hospitalization in connection with the provision of such services; or

(13) where such expenses are for—

(A) the treatment of flat foot conditions and the prescription of supporting devices therefor,

(B) the treatment of subluxations of the foot, or

(C) routine foot care (including the cutting or removal of corns[, warts,] or calluses, the trimming of nails, and other routine hygienic care).

(b) Payment under this title may not be made with respect to any item or service to the extent that payment has been made, or can reasonably be expected to be made (as determined in accordance with regulations), with respect to such item or service, under a workmen's compensation law or plan of the United States or a State *or under an automobile insurance policy*. Any payment under this title with respect to any item or service shall be considered on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for such item or service has been made under such a law or plan *or policy*.

* * * * * * *

CONSULTATION WITH STATE AGENCIES AND OTHER ORGANIZATIONS TO DEVELOP CONDITIONS OF PARTICIPATION FOR PROVIDERS OF SERVICES

SEC. 1863. In carrying out his functions, relating to determination of conditions of participation by providers of services, under subsections (e)(9), (f)(4), (g)(4), (j)(11), [and (o)(6)](*o*)(*6*), *and* (*cc*)(*2*)(*I*) of section 1861, the Secretary shall consult with the Health Insurance Benefits Advisory Council established by section 1867, appropriate State agencies, and recognized national listing or accrediting bodies, and may consult with appropriate local agencies. Such conditions prescribed under any of such subsections may be varied for different areas or different classes of institutions or agencies and may, at the request of a State, provide higher requirements for such State than for other States; except that, in the case of any State or political subdivision of a State which imposes higher requirements on institutions as a condition to the purchase of services (or of certain specified services) in such institutions under a State plan approved under title I, XVI, or XIX, the Secretary shall impose like requirements as a condition to the payment for services (or for the services specified by the State or subdivision) in such institutions in such State or subdivision.

USE OF STATE AGENCIES TO DETERMINE COMPLIANCE BY PROVIDERS OF SERVICES WITH CONDITIONS OF PARTICIPATION

SEC. 1864. (a) The Secretary shall make an agreement with any State which is able and willing to do so under which the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by him for the purpose of determining whether an institution therein is a hospital or skilled nursing facility, or whether an agency therein is a home health agency, or whether a facility therein is a rural health clinic as defined in section 1861 (aa)(2), *or a comprehensive outpatient rehabilitation facility as defined in section 1861(cc)(2)*, or whether a laboratory meets the requirements of [paragraphs (10) and (11) of section 1861 (s)] *paragraphs (11) and (12) of section 1861(s)*, or whether a clinic, rehabilitation agency or public health agency meets the requirements of subparagraph (A) or (B), as the case may be, of section 1861(p)(4), *or whether a facility therein is a community mental health center as defined in section 1861(bb)(2)*. To the extent that the Secretary finds it appropriate, an institution or agency which such a State (or local) agency certifies is a hospital, skilled nursing facility, rural health clinic, *comprehensive outpatient rehabilitation facility*, or home health agency, *or a community mental health center* (as those terms are defined in section 1861) may be treated as such by the Secretary. Any State agency which has such an agreement may (subject to approval of the Secretary) furnish to a skilled nursing facility after proper request by such facility, such specialized consultative services (which such agency is able and willing to furnish in a manner satisfactory to the Secretary) as such facility may need to meet one or more of the conditions specified in section 1861(j). Any such services furnished by a State agency shall be deemed to have been furnished pursuant to such agreement. Within 90 days following the completion of each survey of any health care facility, rural health clinic, *comprehensive outpatient rehabilitation facility*, laboratory, *community mental health center*, clinic, agency, or organization by the appropriate State or local agency described in the first sentence of this subsection, the Secretary shall make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, rural health clinic, *comprehensive outpatient rehabilitation facility*, laboratory, *community mental health center*, clinic, agency, or organization with (1) the statutory conditions of participation imposed under this title and (2) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such health care facility, rural health clinic, *comprehensive outpatient rehabilitation facility*, laboratory, *community mental health center*, clinic, agency, or organization.

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AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a)(1) * * *

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(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1813(a)(1) or (a)(3), section 1833(b), or section 1861(y)(3) with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under part B (but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary). [In the case of items and services described in section 1833(c), clause (ii) of the preceding sentence shall be applied by substituting for 20 per centum the proportion which is appropriate under such section.]

* * * * * * *

OVERPAYMENTS ON BEHALF OF INDIVIDUALS AND SETTLEMENT OF CLAIMS FOR BENEFITS ON BEHALF OF DECEASED INDIVIDUALS

SEC. 1870. (a) * * *

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[(f) If an individual who received medical and other health services for which payment may be made under section 1832(a)(1) dies, and—

[(1) no assignment of the right to payments was made by such individual before his death, and

[(2) payment for such services has not been made,

payment for such services shall be made to the physician or other person who provided such services, but payment shall be made under this subsection only in such amount and subject to such conditions as would have been applicable if the individual who received the services had not died, and only if the person or persons who provided the services agrees that the reasonable charge is the full charge for the services.]

(f) If an individual who received medical and other health services for which payment may be made under section 1832(a)(1) dies, and no assignment of the right to payment for such services was made by such individual before his death, and payment for such services has not been made—

(1) if the person or persons who furnished the services agree that the reasonable charge is the full charge for the services, payment for such services shall be made to such person or persons, and

(2) if the person or persons who furnished the services do not agree that the reasonable charge is the full charge for the services, payment for such services shall be made on the basis of an itemized bill to the person who has agreed to assume the legal obligation to make payment for such services and files a request for payment (with such accompanying evidence of such legal obligation as may be required in regulations),

but only in such amount and subject to such conditions as would be applicable if the individual who received the services had not died.

PROVIDER REIMBURSEMENT REVIEW BOARD

SEC. 1878. (a) * * *

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(f)(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. *Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which such determination is rendered. If a provider of services may obtain a hearing under subsection (a) and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing.* Such action shall be brought in the district court of the United States for the judicial district in which the provider is located or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5, United States Code, notwithstanding any other provisions in section 205.

* * * * * * *

LIMITATION ON LIABILITY OF BENEFICIARY WHERE MEDICARE CLAIMS ARE DISALLOWED

SEC. 1879. (a) * * *

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(e) Where payment for inpatient hospital services or extended care services may not be made under part A of this title on behalf of an individual entitled to benefits under such part solely because of an unintentional, inadvertent, or erroneous action with respect to the transfer of such individual from a hospital or skilled nursing facility that meets the requirements of sections 1861 (e) or (j) by such a provider

of services acting in good faith in accordance with the advice of a utilization review committee, professional standards review organization, or fiscal intermediary, or on the basis of a clearly erroneous administrative decision by a provider of services, the Secretary shall take such or fiscal intermediary, or on the basis of a clearly erroneous administra- may be necessary to correct the effects of such unintentional, inadvertent, or erroneous action.

* * * * * * *

MEDICARE COVERAGE FOR END STAGE RENAL DISEASE PATIENTS

SEC. 1881. (a) * * *

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(c) (1) * * *

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(4) The Secretary shall in determinig whether to certify additional facilities or expansion of existing facilities within a network, take into account the network's goals and performance as reflected in the network's annual report. *The Secretary may not find, for purposes of such certification, that the addition or expansion of a facility within a network is not needed if the State health planning and development agency, fully or conditionally designated under title XV of the Public Health Service Act for the State in which the facility is located, has certified under section 1523(a)(4)(B) of such Act that such addition or expansion is needed.*

* * * * * * *

(e) (1) Notwithstanding any other provision of this title, the Secretary may, pursuant to agreements with approved providers of services [and], renal dialysis facilities, *and nonprofit entities which the Secretary finds can furnish equipment economically and efficiently*, reimburse such providers [and facilities], *facilities, and nonprofit entities* (without regard to the deductible and coinsurance provisions of this title) for the reasonable cost of the purchase, installation, maintenance and reconditioning for subsequent use of artificial kidney and automated dialysis peritoneal machines (including supportive equipment) which are to be used exclusively by entitled individuals dialyzing at home.

(2) An agreement under this subsection shall require that the provider [or facility will], *facility, or other entity will—*

(A) make the equipment available for use only by entitled individuals dialyzing at home;

(B) recondition the equipment, as needed, for reuse by such individuals throughout the useful life of the equipment, including modification of the equipment consistent with advances in research and technology;

(C) provide for full access for the Secretary to all records and information relating to the purchase, maintenance, and use of the equipment; and

(D) submit such reports, data, and information as the Secretary may require with respect to the cost, management, and use of the equipment.

* * * * * * *

(g) The Secretary shall submit to the Congress on [April] *July* 1, 1979, and [April] *July* 1 of each year thereafter a report on the end stage renal disease program, including but not limited to—

(1) the number of patients, nationally and by renal disease networks, on dialysis (self-dialysis or otherwise) at home and in facilities;

(2) the number of new patients entering dialysis at home and in facilities during the year;

(3) the number of facilities providing dialysis and the utilization rates of those facilities;

(4) the number of kidney transplants, by source of donor organ;

(5) the number of patients awaiting organs for transplant;

(6) the number of transplant failures:

(7) the range of costs of kidney acquisitions, by type of facility and by region;

(8) the number of facilities providing transplants and the number of transplants performed per facility;

(9) patient mortality and morbidity rates;

(10) the average annual cost of hospitalization for ancillary problems in dialysis and transplant patients, and drug costs for transplant patients;

(11) medicare payment rates for dialysis, transplant procedures, and physician services, along with any changes in such rates during the year and the reasons for those changes;

(12) the results of cost-saving experiments;

(13) the results of basic kidney disease research conducted by the Federal Government, private institutions, and foreign governments;

(14) information on the activities of medical review boards and other networks organizations; and

(15) estimated program costs over the next five years.

* * * * * * *

Section 7 of the Railroad Retirement Act of 1974

POWERS AND DUTIES OF THE BOARD

Sec. 7. (a) * * *

* * * * * * *

(d)(1) The Board shall, for purposes of this subsection, have the same authority to determine the rights of individuals described in subdivision (2) to have payments made on their behalf for hospital insurance benefits consisting of inpatient hospital services, posthospital extended care services, [posthospital] home health services, and outpatient hospital diagnostic services (all hereinafter referred to as "services") under section 226, and parts A and C of title XVIII, of the Social Security Act as the Secretary of Health, Education, and Welfare has under such section and such parts with respect to individuals to whom such sections and such parts apply. For purposes of section 8,

a determination with respect to the rights of an individual under this subsection shall, except in the case of a provider of services, be considered to be a decision with respect to an annuity.

(2) Except as otherwise provided in this subsection, every person who—

(i) has attained age 65 and (A) is entitled to an annuity under this Act or (B) would be entitled to such an annuity had he ceased compensated service and, in the case of a spouse, had such spouse's husband or wife ceased compensated service; or

(ii) has not attained age 65 and (A) has been entitled to an annuity under section 2 of this Act, or under the Railroad Retirement Act of 1937 and section 2 of this Act, or could have been includible in the computation of an annuity under section 3(f)(3) of this Act, for not less than 24 [consecutive] months and (B) could have been entitled for 24 [consecutive] calendar months, and could currently be entitled, to monthly insurance benefits under section 223 of the Social Security Act or under section 202 of that Act on the basis of disability if service as an employee after December 31, 1936, had been included in the term "employment" as defined in that Act and if an application for disability benefits had been filed,

shall be certified to the Secretary of Health, Education, and Welfare as a qualified railroad retirement beneficiary under section 226 of the Social Security Act.

* * * * * * *

REPRESENTATIVE DANNEMEYER'S ADDITIONAL VIEWS

The Medicare Program is one that has touched the lives of millions of our senior citizens and, as such, refinements of it are hard to criticize, especially when some of them have real merit. However, senior citizens are also the ones most vulnerable to the ravages of inflation and today this nation is facing an inflation rate approaching 20 percent. Thus, the dilemma posed by HR 3990: do we expand, and hopefully improve upon, the Medicare program in hopes that it will better the lot of many senior citizens? Or do we delay making changes in the Medicare statute for fear that the cost will fuel the fires of inflation, or, at the very least, help frustrate efforts to curb it?

There is no easy answer to this question, but it must be addressed. Regardless of its merits, H.R. 3990 is expected to cost the federal government $17 million for the remainder of fiscal 1980, a year in which the budget is expected to be in deficit by some $47 billion, and $186 million for the first full year of the program, fiscal 1981. In fiscal 1982, the cost of the bill, which I might add contains one cost-saving section dealing with Medicaid, will rise to $294 million, and by fiscal 1985, it will be costing the American taxpayers $456 million a year. At a time when we need to cut spending so as to balance the budget and reduce inflationary pressures, that is a lot of money.

What happens if we don't curb inflation? The answer is clear, if not very pleasant: higher prices, higher interest rates, continued loss of purchasing power, uncertainty in the stock market, and continued erosion of the value of pensions and other retirement benefits. Many senior citizens will have to sell their homes to just make ends meet, and the value of whatever benefit increases they might receive now will be eaten up within a very few years.

Admittedly, that is not a very encouraging picture, but if those are the prospects, and more and more Americans are realizing they are, then logic suggests that this is not the time for a program expansion; that, in fact, such an expansion would be self-defeating as long as the inflation rate is well up in the double digits. The only way we are going to be able to cut the inflation rate is to cut the deficit spending by the federal government that produces it. For as long as the money supply has to be expanded to cover deficits, then demand for goods and services relative to supply will continue to increase and prices will inevitably rise. OPEC oil isn't the main culprit; if it was, West Germany and Japan would have far worse inflation problems than we do, and such is not the case.

The sad truth of the matter is that the thing that got us into this mess is the very thing that stands in the way of getting us out: an overabundance of good intentions. For years we have been spending beyond our means—$250 billion worth in the last five years alone—on

what seemed like worthwhile projects, some more worthwhile than others. As we did so, little thought was given to the time when we would have to pay the bill. That time, it seemed, was way off in the future, if it came at all. Well, if the economic indicators are any judge, that time has now arrived, and either we can pay up—which means doing without some things for a while—or risk bankruptcy, not only for some of our citizens, but for the nation as well. Nations, just like people, cannot go on living beyond their means forever.

WILLIAM E. DANNEMEYER.

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